State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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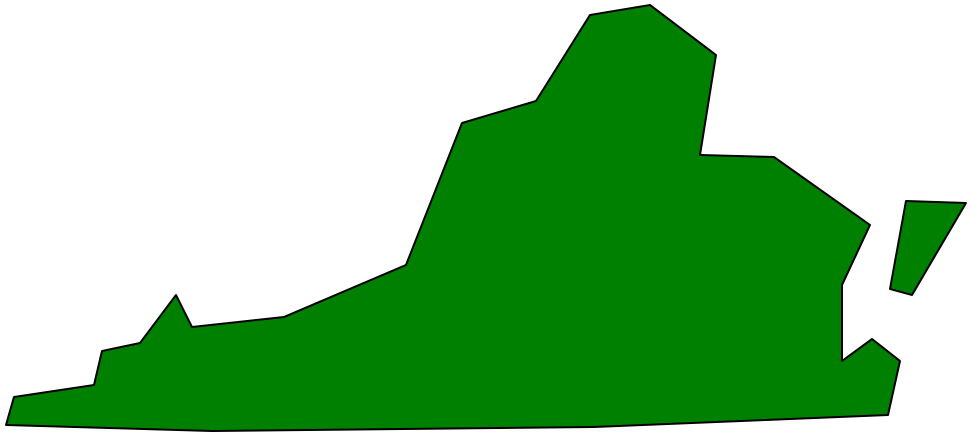
MATERNAL AND CHILD HEALTH SERVICES

FY 2001 BLOCK GRANT APPLICATION NARRATIVE



COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH
July 14, 2000

1.4 Overview of the State

The Commonwealth of Virginia, a mid-Atlantic state, encompasses 40,767 square miles. It is bordered by five other states, Maryland, Kentucky, West Virginia, Tennessee, and North Carolina as well as the District of Columbia. The Chesapeake Bay defines the eastern coast. Virginia extends 440 miles from East to West and 200 miles from North to South. Local jurisdictions are comprised of 95 counties and 40 independent cities totaling 135 localities. The Virginia Department of Health (VDH) has grouped these localities into 35 health districts. Three of the district offices, Arlington, Fairfax, and Richmond are independent with contractual relationships to the state system.

Across the state, the terrain varies widely, including mountainous and coastal regions, remote rural areas and large urban centers. Geography impacts services in several areas. Difficult terrain, lack of medical services and transportation issues pose barriers to health care for families.

Virginia has a great range between its urban and rural areas. Twenty-five communities have densities of less than 50 persons per square mile. Half of Virginia communities have total populations under 20,000 persons, with 24 of those having less than 10,000 persons. However, more that three-fourths of the state population lives within metropolitan areas, according to the U.S. Census.

Virginia ranks as the 12th most populated state with 6,791,000 residents in 1998 marking an increase of 15.8 percent since 1990 according to the U.S. Census Bureau estimates. Projections for the years 2000 and 2025 show the population continuing to rise to 8,466,000 persons. A large part of this growth has occurred in Northern Virginia.

The population in Virginia is 48.9 percent male and 51.1 percent female. The median age of the population is 34.5 years. Virginia has a greater proportion of younger cohorts than seen nationally. Children and teens under the age of 20 make up approximately 28 percent of the populations and women of childbearing age make up 23.6 percent of the population.

Minority groups in Virginia include African-Americans, Asian/Pacific Islanders, Native Americans, and Hispanics. The culturally diverse populations include the following groups: Cambodian, Central American, Chinese, Ethiopian, Filipino, Korean, Loa, Russian/Ukrainian, Somalian, Sierra Leone, South American, Thai and Vietnamese (VDH, Multicultural Health Task Force Report, 1999). The state ranks as 9th largest for immigrant residents and 8th among intended residence for new arrivals. Virginia ranks as having the 16th largest Hispanic population and the 9th largest Asian population in the country. The Census estimates that the Non-Hispanic white population in Virginia will decrease from 72.8 percent in 1998 to 64.7 percent in 2025, while the Hispanic population will increase from 3.7 percent to 6.4 percent and the Asian/Pacific Islander population will increase from 3.6 percent to 5.9 percent. Multicultural population concentrations are greatest in the eastern portions of the state, with Northern Virginia and Tidewater as home to the greatest numbers of minorities.

According to the 1990 U.S. Census, three-fourths of state residents had achieved at least a high school diploma or equivalency. At the latest Census update on educational attainment in 1998, the percentage of high school graduates had risen to 82.5 percent. Overall Virginia education data compares favorable to the nation as more adults in the Commonwealth hold bachelor's degrees or have completed higher education than over two-thirds of the country. In 1996, it was estimated that 8 percent of teens ages 16-19 were high school dropouts compared to 10 percent nationwide, based on a three-year average reported by the Annie E. Casey Foundation. Percentages of educational attainment vary greatly by race and location. African-Americans and Hispanics fared worse that the total state figure of high school graduates at 70.9 percent and 70.4 percent, respectively.

Unemployment in Virginia has fallen to the lowest it has ever been since measurements were begun in the 1970s. In 1998, the average annual unemployment fell to 2.9 percent. Unemployment varies by jurisdiction with the worst unemployment rates largely concentrated in the Southwest and Central Southside areas.

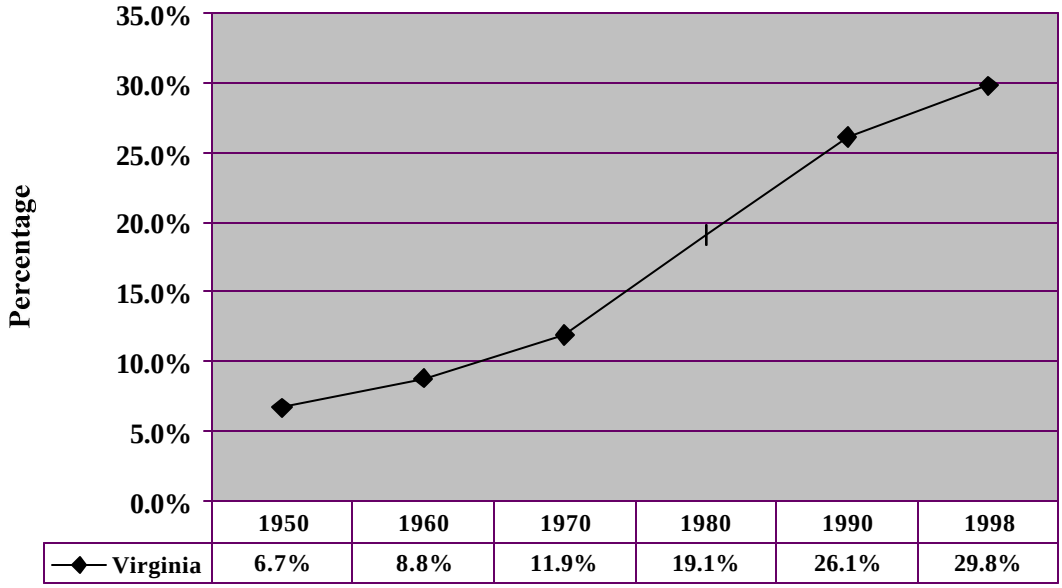
The current poverty rate in Virginia is below the U.S. figure of 12.7 percent. Based on 1998 data, Virginia ranks 47t[h,] having the 3rd lowest statewide poverty rate in the country. In 1997 approximately

13 percent of women ages 15-44 were below 100 percent FPL and 18.6 percent of children under age 18 were below 100 percent FPL. This translates to over half a million persons. The median household income in 1996 was 39,211 (in 1996 constant dollars) which placed Virginia 14th among the states. Median household income, however, actually decreased from the 1990 Census figure of $42,104 (in 1996 constant dollars). Poverty varies significantly by locality, and by family structure. Four cities, Norfolk, Richmond, Virginia Beach, and Newport News and one country, Fairfax, account for over 30 percent of children in poverty.

The decline in the number of two-parent families resulting from increased divorces and nonmarital births impacts the poverty experienced by Virginia children. In 1996, 29 percent of families with children were single parent-headed households (the majority was father-absent families), up 4 percent from the previous year. In 1996 only 42 percent of the families headed by mothers received child support or alimony. Also of concern is the high number of births to unmarried parents. In 1998, almost three out of every 10 live births were to unmarried women. Sixty-eight percent of young children live with married parents, 22 percent with a single parent (most frequently the mother), and 9 percent with a parent who is separated or divorced. Family poverty and community resources impact the ability to obtain health care. In 1999, approximately 10 percent of Virginia's children were without health insurance and approximately 25 percent of children in poverty were without health insurance.

The Office of Family Health Services (OFHS), the office that administers Title V, will continue work during the next year to shift the overall health paradigm to focus on how family structure impacts health and away from the focus on low income women. OFHS continues to remain concerned about family trends that ultimately impact the health of family members. Divorces numbered over 30,000 in 1998. The number of divorces neared half the number of marriages (64,096). The rate of marriages continues to decline and reached 9.5 per 1,000 persons in 1998 down from 10.7 in 1993 (Virginia Center for Health Statistics). The median age at first marriage has also risen both in Virginia and nationally.

Chart : Percent of Nonmarital Births
Virginia 1950-1998



	1950	1960	1970	1980	1990	1998
Virginia	6.7%	8.8%	11.9%	19.1%	26.1%	29.8%

Source Data: Virginia Center for Health Statistics

The percent of nonmarital pregnancies and births has continued the increase begun decades earlier. In 1998, 28,057 nonmaritial births occurred (Virginia Center for Health Statistics). This number is more than double the number twenty years ago. The Annie E. Casey Foundation reports that the percent of Virginia's families that have children and are headed by a single parent rose from 24 percent in 1990 to 29 percent in 1997. Many of these children will not experience the unique contributions that fathers make to their development. These children, on average, are more likely to be poor, experience educational, health, emotional and psychological problems, and engage in criminal behavior than their peers who live with their married, biological mother and father (Horn, 1998). In some Virginia localities, over half of the births are to unmarried parent.

Addressing the issues related to nonmarital births by shifting from a primary focus on women and children to a focus on the family, including the father's role and responsibilities, will be a major challenge for Virginia. Virginia has implemented programs that encourage father involvement and discourage nonmarital births. The Virginia Fatherhood Campaign promotes programs and policies that support father presence in the lives of their children and seeks to improve the quality of fathering. The Partners in

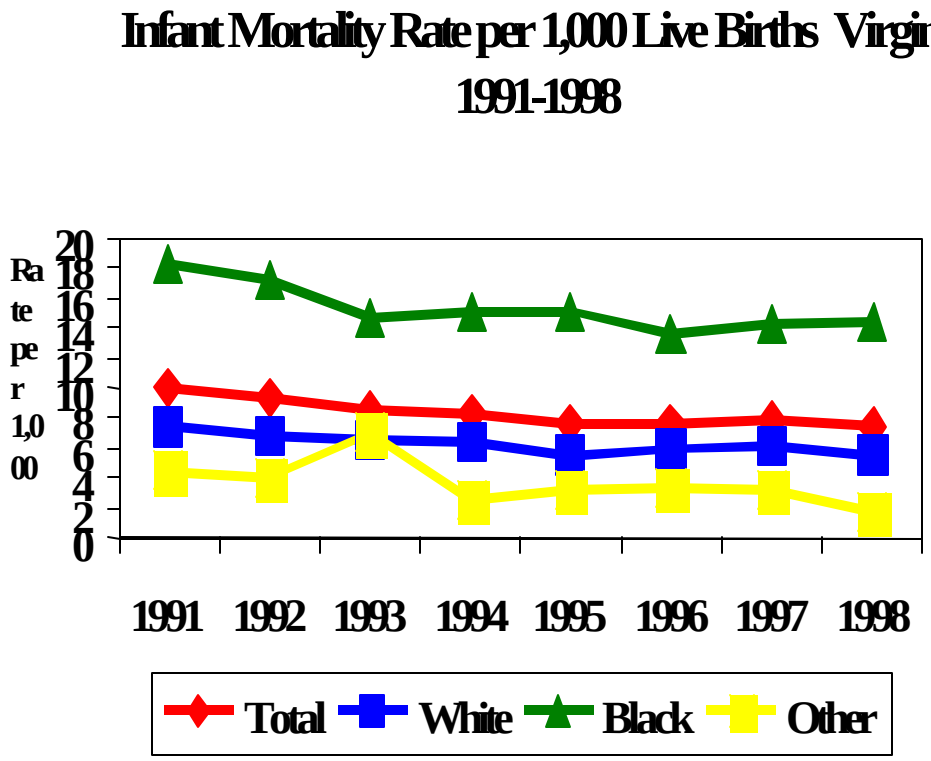
Prevention Program is a partnership with communities to promote the benefits of marriage and develop efforts to decrease the number of nonmarital births.

Specific health status indicators highlight some of the challenges that Virginia faces. Unintentional injuries took the lives of 2,267 Virginians in 1998, making this the fifth leading cause of death. Motor vehicle crashes accounted for approximately four out of every ten of these fatalities. Although there is a continuing decline in child deaths, the leading cause of death for Virginia children is injury. Violent and abusive behavior has been increasingly recognized as an important public health issue. In 1998, approximately 416 people were homicide victims in Virginia (down from 500 homicides in 1997). Of the 416 homicides, 279 (67 percent) were by firearms and explosives. Approximately 16 percent of the deaths in 15-19 year-olds were classified as homicides in 1998. Homicide disproportionately affects the young African American male. During the next year The Center for Injury and Violence Prevention will develop a youth violence prevention program and will work with the Department of Education to address the youth violence issue.

The 2000 General Assembly approved funding of $1.1 million per year in the upcoming biennium to implement the Virginia Right Choices for Youth Initiative. This initiative will focus on the positive healthy behaviors, positive assets, and right choices of youth and not on the negative risk behaviors. The five year goals include building the capacity of state, public, and private entities to work with regional, community/local entities to implement effective youth risk behavior prevention strategies, and increasing knowledge about the importance of parent and child connectedness, and school connectedness as protective factors for youth.

The racial disparity in a number of health status indicators also presents significant challenges. For example, the infant mortality rate is often used as a state health status indicator. In 1998, the rate was 7.4 per 1,000 live births. However, there continues to be an increasing disparity between the rates for white and for African-American infants (see graph below). In 1998, the rate for white infants was 5.5/1,000 as compared to 14.5/1,000 for African American infants. The infant mortality rates vary

geographically with the highest rates in Richmond, Norfolk and Portsmouth and in the Crater, Piedmont, Peninsula, Southside, Lenowisco, and Western Tidewater.

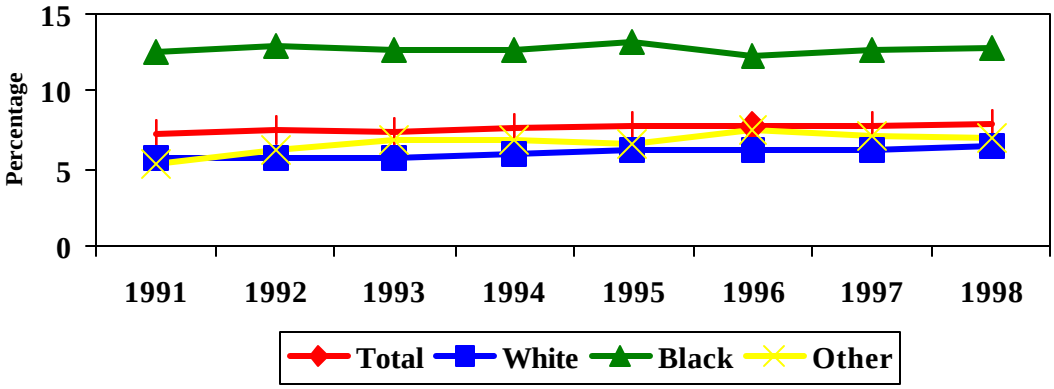


Source Data: Virginia Center for Health Statistics

Of Virginia women having a live birth in 1998, 84.8 percent had received early prenatal care. During the same period, 1 percent of women had received no prenatal care throughout their pregnancy. There continues to be differences based on race, in the proportion of women who receive early prenatal care. Among white women giving birth in 1998, approximately 89 percent received prenatal care in the first trimester while 74 percent of African-American women and 73 percent of Hispanic women received early prenatal care. The gap in early prenatal care between white mothers and mothers of African-American and other races in Virginia has not changed from 1995 through 1998. Lower utilization by Hispanic women also reflects racial and ethnic disparities which may be magnified for immigrants who may fear contact with the medical system, encounter language barriers, or have a lack of resources and knowledge to obtain care.

Low birth weight is an indicator of limited access to health care and a major predictor of infant mortality. In 1998, 7.9 percent of all live births were low birth-weight infants. Of these, the percentage of low weight births for African Americans (12.7 percent) was almost double that for whites (6.5 percent).

Resident Low Weight Live Births Percent of Total Live Births Virginia, 1991-1998



Source Data: Virginia Center for Health Statistics

Pregnancy rates for teens aged 15-17 decreased over the past five years to 41.9 per 1000 females in 1998. However, the black teen rate (82.6) remained more than double that in white teens (29.9). Teen pregnancy is a critical public health issue that affects the health, educational, social, and economic future of the family. Some areas of the state had rates more than twice this level. The Virginia Abstinence Education Initiative was recently implemented to address this issue.

Virginia will also be required to meet a number of other significant challenges in addressing the health needs of families. These challenges will come from the changing role of government and state policies. Over the past few years, citizens have rightfully demanded that governments and all service providers be more responsive and more accountable. At the same time there is a recognition that citizens are demanding "less government" and more autonomy in making decisions that impact their communities. Like other states, Virginia is continuing to analyze the business of government and health care to ensure that the needs of the citizens are addressed. One such effort is the Virginia Turning Point Initiative.

In 1998, the Virginia Department of Health, in partnership with the Virginia Hospital and Healthcare Association, was awarded a *Turning Point* grant from the Robert Wood Johnson and W.K. Kellogg foundations. Virginia's *Turning Point* has four major goals: to obtain community input on the roles and responsibilities for public health agencies; to improve decision makers' understanding of and value for the contributions that public health and its partners make to create and sustain healthy communities; to develop, collect, analyze, and share health-related data that support information-based decisions for Virginia communities; and to ensure that the public health work force has the skills needed in the future.

During the first two years of the Turning Point Initiative, activities focused on obtaining community feedback on the future roles and responsibilities of public health. This resulted in the development of a website, group presentations, a statewide telephone survey, key informant discussion groups and regional forums. From this feedback it was determined that the most critical needs for Virginia public health relate to information and education, and changing the "ownership" of public health so that every sector, public and private, works together to invest in the future of public health. As a result, the two overarching recommendations are to launch a Community Health Improvement Plan and create a Center for Community Health.

Virginia was recently awarded funding from Robert Wood Johnson Foundation to implement the four-year Turning Point Community Health Improvement plan. The plan includes performing community health needs assessments, assessing the economics of prevention, and promoting public health awareness. The creation of a Center for Community Health with public/private governance and leadership will greatly increase the opportunity for public health research, and create an independent voice for public health issues. The Center will work to study the costs, benefits and long term implications of health policy decisions related to public health by facilitating collaborative efforts between public health and its partners.

Turning Point will also continue to work on improving the effectiveness of the Virginia Department of Health in performing the core public health functions of assessment, policy development and assurance.

Three significant state policy changes may have varying effects on access to health care for women, infants and children in Virginia. The policy changes include welfare reform, the statewide implementation of Medicaid managed care and the implementation of the new state children's health insurance plan. Welfare reform is fully implemented in Virginia. The reform has been successful in reducing Virginia's Temporary Assistance to Needy Families (TANF) caseload from 70,797 families in 1995 to 39,218 in 1998. All welfare recipients, except those in certain categories, are required to work for their benefits in paid or volunteer positions. The welfare reform program includes sanctions for noncompliance. Increased benefits are not available for additional children born 10 months or more after eligibility. Failure to have children immunized results in penalties. Virginia welfare reform requires that mothers identify the father of their children. Although one obvious health benefit of the welfare reform initiative is the immunization requirement, and a potential benefit is an increased involvement of fathers, the future effect on health and health care access requires continued assessment. In Virginia, Medicaid benefits may be extended for up to one year following increased earnings or job program enrollment for TANF enrollees. National concerns, however, remain over the delinking of TANF and Medicaid with potentially Medicaid eligible persons losing coverage. A 1999 Joint Legislative Audit and Review commission (JLARC) study found that 61 percent of former TANF recipients who had participated in the Virginia Independence Program's (VIP) employment initiative were working, yet only 27 percent had jobs with health coverage. With the average wage of $6.55/hour, purchasing health coverage may be cost prohibitive and the income may be sufficient to make their families ineligible for Medicaid coverage. The percentage of all Medicaid enrollees under TANF/AFDC categories continued falling to its lowest point in FY 99. The impact of welfare reform on health care for women, infants and children and on health department caseloads and resources remains an area for continued assessment.

The 1998 Session of the Virginia General Assembly included a budget amendment for FY 99-00 that provided for the implementation of a health insurance plan for low-income children. This insurance program is designed to assist working families with uninsured children. The funding addresses the federal legislation establishing the State Child Health Insurance Program under the new Title XXI of the Social Security Act. Under federal law, each state has the option to expand Medicaid, create their own

children's health insurance program targeting low-income children or implement a combination of the two.

Virginia adopted a plan in 1998 that created the Children's Medical Security Insurance Plan (CMSIP). This program has been designed for uninsured children who have not had health insurance for the past 12 months and who are not eligible for Medicaid or the state employee health insurance plan. This is not an expansion of Medicaid under Title XIX of the Social Security Act, but a program that provides Medicaid-equivalent benefit coverage for children in families up to 185 percent of the federal poverty level. The CMSIP does not currently require premiums and/or co-payments, but in the future. The Department of Social Services (DSS) has the responsibility for determining eligibility, enrolling people, and implementing a statewide outreach program. Since its inception the Virginia Department of Health (VDH) has supported the outreach effort by hosting "local health summits" to bring participants from schools, providers, community service organizations and local governments together. The state WIC program has mailed out over 100,000 packets containing CMSIP information and an application. Increasingly, local health departments are also involved in CMSIP outreach efforts.

The Virginia Joint Commission on Health Care estimated that 72,000 children were eligible for CMSIP at its inception. As of June 19, 2000, 24,680 children were enrolled. Identified barriers to enrollment include the perception that CMSIP is a "welfare" program and a complicated application process. To reduce barriers and increase enrollment, CMSIP will be replaced by the Family Access to Medical Insurance Security Plan (FAMIS), as mandated by Senate bill 550 in the 2000 Virginia General Assembly. The Department of Medical Assistance Services (DMAS) has the lead role in the development and implementation of this program. A federal waiver is being prepared for submission in July 2000. FAMIS will increase coverage to children in families up to 200 percent FPL who do not qualify for Medicaid and have not had health insurance coverage for the past 6 months. FAMIS will provide premium assistance to participants who have access to employer-sponsored health insurance if deemed cost effective. Wrap-around services such as dental, vision, mental health and substance abuse will be provided if not part of regular employer coverage. FAMIS will include some cost sharing with limits based on FPL. Unlike CMSIP, state administration will be within one centralized site to be

managed by DMAS. The application form will be shortened to one page. Local social service agencies, contracting health plans, providers and others will be able to provide application assistance and enroll children in FAMIS or Medicaid as appropriate. Title V staff will serve on the Outreach Oversight Committee required by law. The FAMIS Outreach Plan is required to include specific strategies for improving outreach and enrollment in localities having less than statewide average enrollment and enrolling children of former TANF recipients. The change from CMSIP to FAMIS will require continued assessment to ensure that children's health care needs are being met.

The Commonwealth continues to expand Medicaid managed care. Medallion II, a managed care program for the Virginia Department of Medical Assistance Services (DMAS), requires mandatory enrollment in a contracted Health Maintenance Organization (HMO) for certain groups of Medicaid recipients and Children Medical Security Insurance Plan (CMSIP) enrollees. Medicaid recipients excluded from managed care enrollment are: long term care residents; recipients participating in federal waivers; recipients with comprehensive insurance coverage, including Medicare; foster care children, aliens and refugees.

In 1996, mandatory managed care enrollment in a contracted HMO began in seven Tidewater cities. The next expansion occurred in 1997 to include an additional six cities and counties in the surrounding Tidewater area. Beginning April 1, 1999, approximately 69,000 Medicaid recipients and CMSIP enrollees were transitioned into the Medallion II program in the Central Virginia Region. This area consists of the Richmond metropolitan area, Eastern Shore and the Southwest Tidewater areas. Currently, enrollees have a choice of one of six contracted HMOs. If an enrollee does not choose a specific HMO within 60 days, an assignment to an HMO will be made for them considering their current Options HMO, Medallion Primary Care Provider, family members and geographic location. DMAS has contracted with an enrollment broker to provide education and enrollment functions. HMOs are not allowed to directly market or enroll Medicaid recipients. Required enrollment in an HMO will continue to be phased in throughout the Commonwealth. Many HMOs are currently constructing statewide networks in an effort to compete for these broadening contracts. The changing health care delivery

system requires that OFHS continue to monitor the impact on women, infants and children's health and on health department caseloads and resources.

The needs assessment process served as a tool for the OFHS to reflect on system changes and examine health status of Virginia's families. The overall health status of Virginia's families has continued to improve in the past five years as evidenced by declining mortality rates, most noted in infants and children. Deaths due to low weight births, congenital anomalies, and unintentional injuries have decreased. Health status, however, remains unequal with variations seen by race, income, age, insurance coverage, family structure, and residency. These variations present challenges for us during the next five years. During the next year OFHS's efforts will focus on the improving health outcomes by strengthening families, improving the quality of clinical, preventive and community services, improving access to health care and health insurance, promoting health behaviors, reducing racial disparities in health outcomes, and providing accurate, reliable, timely public health data and information.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The VDH is mandated by the *Code of Virginia* to "administer and provide a comprehensive program of preventive, curative, restorative and environmental health services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research, and abate hazards and nuisances to the health and environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth." In carrying out these responsibilities, VDH promulgates and enforces over 60 sets of regulations and manages over 70 federal and state grants. Organizationally VDH consists of a Central Office, 35 health districts, with numerous operational sites and hundreds of contractors. Three of the district offices, Arlington, Fairfax, and Richmond are independent with contractual relationships to the state system.

Section 32.1-77 of the *Code of Virginia* specifically addresses VDH's authorization to prepare and submit to the U.S. Department of Health and Human Services the state Title V plan for maternal and

child health services and services for children with special health care needs. The Commissioner of Health is authorized to administer the plan and expend the Title V funds.

Within the central office of VDH, the Maternal and Child Health Services Block Grant is managed by the Office of Family Health Services (OFHS). The OFHS mission and organizational placement within VDH remain the same as described in previous Maternal and Child Health Services Block Grant applications. (**Appendix B**)

Governor James S. Gilmore, III is in the third year of his term. Claude A. Allen, appointed by Governor Gilmore in 1998, continues to serve as the Secretary of Health and Human Resources. E. Anne Peterson, M.D., M.P.H. formerly the Acting State Health Commissioner was officially appointed to the position in late 1999. The position of Deputy Commissioner for Policy and Health Care Delivery, formerly held by Clydette L. Powell, M.D., M.P.H., is currently vacant. Robert Stroube, M.D., M.P.H. is currently the Acting Deputy for Health Programs.

1.5.1.2 Program Capacity

The OFHS is organized to address the specific needs of the Title V target populations which include women and infants, children, adolescents and children with special health care needs. Donald R. Stern, M.D., M.P.H. was named as director of the OFHS in 1997. He previously served as the director in OFHS in 1993 and then as the Acting State Health Commissioner and the Deputy Commissioner for Health Programs. (See resume in **Appendix C**) Two of the divisions within the OFHS address the specific target populations, and the other two divisions and one center address specific program areas relating to chronic disease, nutrition, dental health and injury and violence prevention. At the office level, the Policy and Assessment Unit, formerly the Research and Analysis Team, (see Section 1.5.1.3 for a discussion of the Unit's activities) and the Business Unit provide support for the entire office. William Bulluck was apppointed OFHS Business Manager in the fall of 1999, following the resignation of Joan Martin. The following describes the OFHS Divisions and the Center for Injury and Violence Prevention:

The Division of Child and Adolescent Health (DCAH) provides leadership in planning, developing and implementing efforts to improve the health of children and adolescents in Virginia, including services for children with special health care needs (CSHCN). Services include assessment of child and adolescent health issues, identifying resources, informing the public about child and adolescent health issues, providing assistance to state policy makers, developing programs and information systems, and providing clinical consultation and education activities. The specific program areas addressed by the DCAH include adolescent health and pregnancy prevention, child development services, children with special health care needs, lead poisoning prevention, fatherhood, early childhood health, school health, primary care and quality assurance, and speech and hearing services including the newborn hearing screening program. The Division is also responsible for administering the Virginia Abstinence Education Initiative. A major component of the DCAH is the services for children with special health care needs. This component consists of the Child Development Services Program and the Children's Specialty Services Program. The Child Development Services Program ensures the availability and accessibility of comprehensive developmental services to children and adolescents through a network of 11 child development clinics. The Children's Specialty Services Program currently provides specialty medical and surgical care to medically indigent children with special health care needs through clinics in six regional centers and 28 communities statewide. Nancy Bullock, R.N., M.P.H. is the CSHCN program director. Cecilia E. Barbosa, M.P.H., M.C.R.P. is the Division Director. (See resume in **Appendix C**)

The Division of Women and Infants Health (DWIH) provides procedural and policy oversight for women's and infants' health. Services include assessment of women's and infants' health issues, identifying resources, informing the public about health issues impacting women and infants, providing assistance to state policy makers, developing programs and information systems, and providing clinical consultation and education activities. The specific program areas addressed by the DWIH include reproductive health, maternity and perinatal health, the Resource Mothers Program, genetics and newborn screening, neonatal/infant health, breast and cervical cancer detection, and the Partners in Prevention initiative to reduce out-of-wedlock births. The DWIH

also administers the Virginia Healthy Start Initiative and the Title X-Family Planning Grant. Joan Corder-Mabe, R.N.C., M.S., W.H.N.P. is continuing as the Acting Division Director until a permanent director can be recruited. (See resume in **Appendix C**)

The Division of Dental Health (DDH) provides leadership in planning, developing and implementing a coordinated oral disease prevention and education program to promote optimal oral health for all Virginians and a primary care program to assure access to dental care for special populations. The specific program areas addressed by the DDH include community water fluoridation, school fluoride mouth rinse, dental sealants, baby bottle tooth decay prevention, school-based community dental health education, and clinical dental services provided through local health departments. Karen C. Day, D.D.S., M.P.H. is the Division Director. (See resume in **Appendix C**)

The Division of Chronic Disease Prevention and Nutrition (DCDPN) provides leadership in planning, developing and implementing efforts to reduce the morbidity and mortality of chronic diseases and improving the nutritional status of Virginians. The division seeks a variety of funding sources to pay for chronic disease interventions, coordinates and facilitates statewide activities that seek to prevent chronic diseases, seeks opportunities to assist local communities in establishing chronic disease prevention programs, and provides resources, guidance and support for chronic disease projects initiated by other agencies. The Tobacco Use Control Program is also a component of the division. This program manages the Virginia component of the Centers For Disease Control (CDC) National Tobacco Use Prevention Project. The DCDPN also provides nutrition-related services such as assessment of prenatal, infant, and child nutrition, identifying resources, informing the public about nutritional issues, providing assistance to state policy makers, developing nutritional programs, and providing clinical consultation and professional education activities. Nutritionists from the division continue to provide technical assistance to the other divisions. Other specific nutrition-related projects include the Childhood Obesity Project, the nutritional component of the Virginia Healthy Start Initiative, the Folic Acid Awareness Campaign, Osteoporosis Education Campaign, and the Five a Day for Better Health

Campaign. The Division also administers The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Donna Seward, B.S. was recently appointed as the Division Director. She has approximately 24 years of public health management experience and most recently served as the WIC Director in El Paso, Texas. (See resume in **Appendix C**)

The Center for Injury and Violence Prevention (CIVP) was established at the office level in 1998. The injury prevention initiative was formerly located in the Division of Child and Adolescent Health (DCAH) and focused on unintentional childhood injuries. The establishment of the Center expands the injury prevention focus to include intentional injuries and broadens the target population to include adults. The Sexual Assault Program, previously located in the Division of Women's and Infants' Health, is also administered by the CIVP. Erima Fobbs, M.P.H., formerly the Injury Prevention Director in DCAH, continues to serve as the CIVP director. (See resume in **Appendix C**)

Additional OFHS Activities and New Initiatives:

Office of Family Health Services Strategic Plan

In the past few months the OFHS Management Team, consisting of the OFHS Director, the Division Directors, the CIVP Director, the Business Manager, and the Senior Policy Analyst, has been involved in developing the OFHS strategic plan. Following the development of the plan, each division and the CIVP developed their operational plan for SFY 01. The following are the OFHS strategic goals that will guide our activities, including our grant related activities, over the next years:

1. Improve health outcomes by strengthening families.
2. Improve the quality of clinical, preventive and community-based services.
3. Develop the capacity to meet customers' needs for accurate, reliable, timely and relevant public health information and assure its use in decision-making.
4. Improve access to health services and health insurance.

5. Improve identification of "at risk" populations and assure linkage with prevention and early intervention.
6. Reduce (racial/ethnic) minority disparities in health status.
7. Promote healthy behaviors.

In order to enhance the effectiveness and efficiency of OFHS, the Management Team has committed to a strategic planning process that includes a yearly review and update of the plan. The OFHS Strategic Plan will provide direction for all OFHS work and resource plans and allocations. In addition, the OFHS Management Team is currently assessing the organizational structure of the office to ensure that the organizational structure maximizes our ability to accomplish the OFHS goals.

Grant Allocations to the District Health Departments

In 1998, an advisory committee made of district health department staff was established to develop recommendations for new allocation methodologies for the funds from four federal grants that support district health department services (MCH, Preventive Health and Health Services (PHHS) block grant, Title X-Family Planning, and WIC). The field advisory committee provided their new allocation recommendations to the OFHS management team. The Title V allocations for perinatal and child health were previously awarded based on a historical funding pattern and did not reflect changing demographics. The new methodology shifts to a needs-based methodology over time. Last year was the first year the new methodology was used. The districts received 80 percent of previous year's funding, plus 20 percent based on the district's proportion of the poverty births (200% FPL). This year the districts will receive 60 percent of the original funding, plus 40 percent based on the district's proportion of poverty births. The funding for the Child Development Clinics will remain the same for the next year.

Last year, the OFHS implemented a new district application process for MCH and PHHS funds. A joint application was developed for MCH and PHHS to encourage and enable the districts to assess the needs of the community and fund priority programs based on community needs and the

funding source requirements. This gave the districts more flexibility to target specific maternal and child health needs with both MCH and PHHS funds if they chose. The districts are required to develop a plan that is then reviewed by OFHS staff. All plans must be approved prior to the awarding of funds to the district. The joint application process will continue this year with additional accountability requirements. The OFHS program staff assigned to the district will present a summary of the district's performance to the OFHS Management Team. Districts that do not meet agreed upon performance measures this year will not receive funding in the third year. Future plans include the continued refinement of standardized site monitoring and performance measure reporting by the districts.

OFHS Family and Community Health Advisory Committee

The new OFHS Family and Community Health Advisory Committee met for the first time in September to learn about the Title V and Preventive Health and Health Services grant so that they can advise the department in the coming years. The committee also met in March to review Virginia's health status assessment and provide recommendations for the MCH and PHHS grant applications. Committee members represent different geographical regions, major players among the health professions, medical schools, parents of CSHCN, and those groups concerned with the populations served by the grants. The committee has the following purposes

- Make recommendations to the State Health Commissioner through the OFHS about critical public health issues related to healthy families and communities.
- Review and comment on the health status issues being addressed by the OFHS with input on targeted population groups and ideas for obtaining impact to improve health outcomes.
- Provide input on public health issues that should be considered by OFHS in developing program priorities to reduce morbidity and mortality of selected populations.

- Review and comment on the State's PHHS Annual Plan and the MCH block grant application and to assist in gathering public comment on these documents.

1.5.1.3 Other Capacity

Thirty-six and a half full-time equivalent positions (FTEs) in the OFHS are responsible for administering the Title V program. Curriculum vitae for the OFHS director, the division directors, and the Center for Injury and Violence Prevention director are provided in Section 5.3.

The Policy and Assessment Unit, formerly the Research and Analysis Team, is located at the office level. The unit consists of a senior policy analyst, a managed care policy analyst, a senior statistical analyst, a health systems analyst (the State Systems Development Coordinator), and a public relations specialist. Recruitment for a grants management specialist is currently underway. This new position will coordinate the PHHS grant activities, provide technical assistance to OFHS staff and the district staff on grant writing and performance measure development and monitoring. Individual staff within the unit also have responsibility for managing the Title V block grant, the PHHS block grant, the SSDI grant, the Behavior Risk Factor Surveillance System (BRFSS), the MultiCultural Health Task Force, the Managed Care Team, the Web Development Team and the Data and Information Team. The Unit also organizes various statistical analysis training sessions for staff. Future plans include employing an epidemiologist and an evaluation specialist.

OFHS provides a number of opportunities for family input into the MCH and CSHCN programs. A parent satisfaction survey is used to assess the services provided by the Children's Specialty Services and the Child Development Clinics. Parent focus groups have provided information on the Lead Program outreach methods. Parents also serve on various advisory boards, as task group members, and as presenters for in-service training. For example, a parent served on an expert panel for a legislative study on Group B Streptococcal Infection in Women. The parent assisted in developing statewide education materials that were distributed to over 8,000 medical professionals and families. Family representatives also serve on the Regional Perinatal Coordinating Councils, the Hemophilia

Advisory Board, the Virginia Lead Task Force, and the OFHS Family and Community Health Advisory Committee. A parent representative of the Virginia SIDS Alliance served on a task group to evaluate and restructure the Virginia SIDS Notification and Referral Program. Parents also served on the CSHCN Advisory Task Force. OFHS staff participate in a number of organizations supported by families, such as the Virginia Chapter of the Hemophilia Foundation, Spina Bifida Foundation, Cystic Fibrosis Foundation, Virginia SIDS Alliance, Community Center for the Deaf and Hard of Hearing, Virginia Parents Against Lead, and the Virginia Congress of Parents and Teachers.

1.5.2 State Agency Coordination

In Virginia, state health and human service agencies are organized under the jurisdiction of the cabinet level Secretary of Health and Human Resources who is appointed by the governor.

The major health and human services agencies include the Department of Health, the Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Social Services. Juvenile Justice and the Department of Corrections, and the Department of Education are located under different cabinet secretaries. The Health and Human Resources Secretariat also includes a number of advisory boards that provide opportunities for coordination including the Maternal and Child Health Council, the Virginia Council on Coordinating Prevention, the Governor's Advisory Board on Child Abuse and Neglect, and the Child Day Care Council. Neither the Maternal and Child Health Council or the Virginia Council on Coordinating Prevention have been convened during the past year. A number of the health and human services agency heads are represented on these advisory boards.

There are also ongoing opportunities to work with Virginia's health education programs and universities. For example, during FY 98, OFHS contracted with the Medical College of Virginia for three training sessions to develop OFHS staff knowledge and skill in data analysis. In addition, OFHS also worked closely with the Center for Pediatric Research, Eastern Virginia Medical School, in analyzing costs associated with low birth-weight infants, children's hospitalizations, and the development of a school

health information system. Virginia Polytechnical Institute and State University also provided assistance in coalition building and program evaluation. Virginia Commonwealth University provided assistance with the Behavior Risk Factor Surveillance Survey (BRFSS), adolescent focus groups, and program evaluations including the Abstinence Initiative evaluation. The University of Virginia recently provided assistance related to youth violence prevention activities.

Contracts with the tertiary care centers for genetic consultation/services and for specialized services for children with special health care needs are also maintained. In the past, OFHS has contracted for primary care services through the community health centers. For a discussion of formal collaborative agreements see Section 4.2.

DMAS developed a Medicaid managed care workgroup with representatives from the five Medicaid managed care organizations, DSS and VDH. Representatives from Healthy Start and Children with Special Health Care Needs presented to the group. A second work group was formed to review prenatal, infant, children and CSHCN issues such as: the entry into prenatal care procedures, identification of CSHCN, and services for CSHCN. Discussions have centered around early enrollment in Medicaid or the CHIP program. The perinatal nurse consultant, the Baby Care liaison, the Children with Special Health Care Needs director, the director of the Child and Adolescent division, and the EPSDT coordinator participate in this group which includes representatives from all the major state human services departments and the managed care groups.

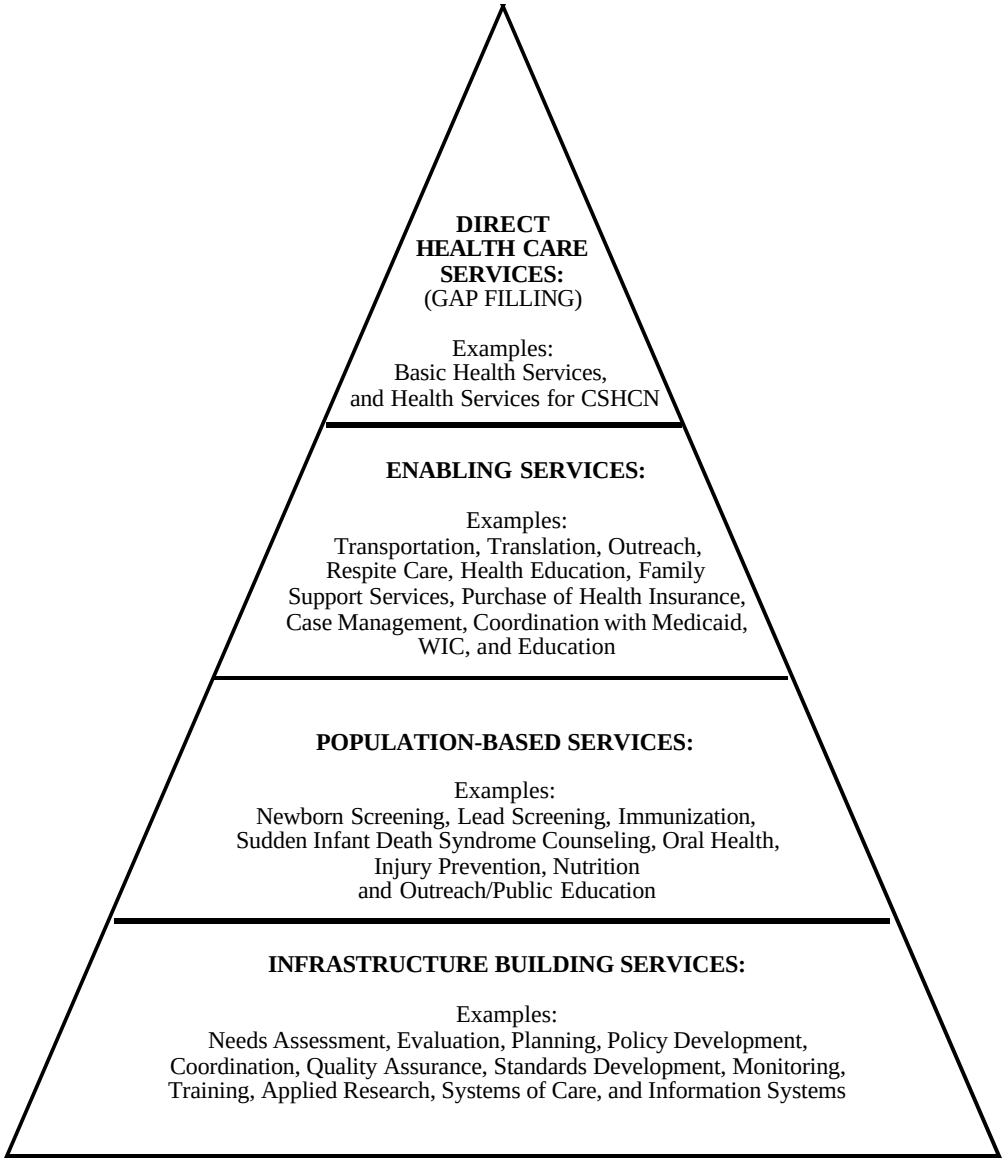
II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

(See Forms 3,4, and 5 in Section 5.8)

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/DSCH 10/20/97

2.2 Annual Number of Individuals Served

(See Forms 6, 7, 8, and 9 in Section 5.8)

2.3 State Summary Profile

(See Form 10 in Section 5.8)

2.4 Progress on Annual Performance Measures

FY 99 activities that Virginia's Title V Program performed or participated in through sponsorship or support are designated below according to the level of services (direct medical care, enabling, population-based, and infrastructure building), and the target population groups (women and infants, children and adolescents, and children with special health care needs). The federally required core performance measures (CPM) and the state performance measures (SPM) that will be monitored to determine future progress are referenced. Additional activities essential to the state's leadership role in maternal and child health care are also included as appropriate. Where data are not available yet for 1999, performance measures are provided for FY 98. (See Form 11, Section 5.8)

2.4.1 Direct Services

2.4.1.1 Women and Infants

In FY 99, the Maternal and Child Health (MCH) Services Block Grant continued to support family planning and prenatal services provided through the network of 35 district health departments at 148 local health department service sites. Family planning services included: complete medical history and physical assessment; routine laboratory testing; HIV risk assessment, counseling and testing; a wide choice of contraceptive methods, including sterilization, Norplant and Depo-Provera; treatment of routine gynecologic problems including STDs and referral and follow-up for other identified problems; education and counseling; and pregnancy testing. Service charges were based on a sliding scale adjusted for family size and income. In FY 99, a total of 85,204 family planning patients were served and all the clinics serving women of childbearing age had specific efforts focused on cervical cancer

early detection. These efforts addressed *SPM#3: The percent of family planning and maternity clinic patients who had a Pap smear in the last year.* During FY 99, 73.1 percent of women of childbearing age seen in maternity or family health department clinics were provided Pap smears. Women with abnormal findings were referred to treatment and tracked to assure treatments were completed. High-grade squamous intra-epithelial lesions (HGSIL) were identified in 338 women. These women were referred for follow-up treatments.

Prenatal clinics continued to be conducted in 32 health districts during FY 99. In one health district prenatal care was provided contractually with a university-based hospital system. A few sites also delivered prenatal services through specific arrangements with a local hospital, physician, or a nearby health clinic. Prenatal services included pregnancy evaluation, risk assessment and intervention (including high-risk care management in some areas), psychosocial assessment and education. These districts provided maternity services for 17,361 pregnant women of all ages in FY 99. The three districts without clinical prenatal care, provide case management services for pregnant women. Title V funding to the health districts supported the salaries of direct care personnel such as physicians, public health nurses, health educators, social workers and outreach workers and provided funding for laboratory and pharmacy costs, including prenatal vitamins**.** Virginia Department of Health (VDH) continued folic acid education in family planning clinics.

All local health departments participated in the Special Supplemental Nutrition Program for Women, Infants, and Children Program (WIC). Services were provided as an integrated part of prenatal clinics or in separate WIC clinics for women, infants and children referred from private sector providers. Title V provided additional funding in FY 99 to provide intensive nutrition services for pregnant women who are considered at high-risk.

During FY 99 a special advisory group consisting of OFHS staff and local health district representatives met to rework the methodology used to allocate Title V funds to the districts. Based on a newly developed formula which accounts for poverty births in each locality, district allocations will be transitioned over four years beginning in FY 00 until total funding is based on this indicator. In addition, performance based

measures were mandated for all districts receiving Title V funds. OFHS is working to better develop district capacity to create and evaluate measurements as well as standardize performance measures at the Office level. These activities further the OFHS role in promoting and monitoring quality assurance for community-based preventive services.

2.4.1.2 Children

Some well-child care services were provided at all local health departments, although the specific services provided and the ages served varied among localities. The *Code of Virginia* mandates local health departments to provide immunizations and school entrance exams for indigent children. Title V funding continued through June 30, 1999, for primary care projects in Alexandria, Hampton, Norfolk, and Roanoke health districts to address community needs.

Funding continued for dental sealant projects in seven local health departments. These projects placed 2,475 dental sealants on children's teeth in FY 99. The FY 99 objective was met for *CPM#7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.* However, measurements for this objective are based on a sample from only a few localities, which differ by year and are not necessarily representative of the entire state. The Division of Dental Health is in the final stages of conducting a dental needs assessment that includes third graders.

2.4.1.3 Children with Special Health Care Needs

The FY 99 performance objective was met for *CPM#2: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.* The Title V program served children with special health care needs through a state service delivery system consisting of Children's Specialty Services, Child Development Clinics, Genetics Centers, and the Metabolic Treatment Program.

The Children's Specialty Services (CSS) Program served children from birth through age 20 who have congenital or acquired physical conditions specified by the Virginia Board of Health. The specified conditions and eligibility requirements remained the same for this year. CSS consists of the following components: 1) statewide clinic services, 2) multi-disciplinary professional team services, 3) case management services, and 4) payment for hospitalization, physician clinic services, and ancillary services. Clinic services were provided through a network of six regional medical centers having specialty clinics for comprehensive diagnosis, treatment, and surgery services. Field clinics were conducted in various settings with local health departments having the responsibility for case finding, initial eligibility determination, counseling and case management. Medical nutrition therapy was provided to patients attending the CSS clinics. In addition, the program provided a full pediatric evaluation for new patients who were without a local primary care provider at the time of admission to a CSS program. In SFY 99, 6,610 patients were provided CSS clinical services.

The Child Development Clinics (CDC) provided a system for the early identification, diagnosis and treatment of developmentally delayed and/or disabled children. Multi-disciplinary teams provided diagnostic and case management services to families and consultation to primary pediatric health care providers, schools, social services and other programs. An automation plan, instruction manual, and training were completed to enable program data entry at all 12 child development clinic locations. The CDC provided services to 3,661 patients in SFY 99.

Genetics testing, counseling, and treatment services were made available through contracts with four Genetics Centers and two Metabolic Treatment Centers. Special formulas were provided for children with a metabolic disease diagnosed through the Newborn Screening Program.

The FY 99 performance objective was not met for *CPM#1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.* All eligible CSS and CDC patients were encouraged to enroll in SSI. VDH has an agreement with the Social Security Administration and the Virginia Department of Rehabilitative Services for informing VDH of new applicants for SSI. VDH sends a

letter to the families informing them of services available through Title V, local health departments and other state agencies.

2.4.2 Enabling Services

2.4.2.1 Women and Infants

Case management of maternal and infant care coordination is provided in 34 of the 35 health districts. The majority of these clients are under the Medicaid Baby Care program. Title V funds support local case management services for patients without a payment source. In FY 99, health departments provided case management services to a total of 5,043 infants and 3,669 pregnant women.

The health districts employing perinatal nutritionists continued to implement the Nutrition Intervention Program (NIP) for Underweight Pregnant Women. Local offices currently track outcomes. The state office had planned to collect data on NIP participants using the WIC Program computer information system (WIC-Net), but system implementation has been delayed. Statewide outcome data are not currently available.

Through a federal Healthy Start grant, the Virginia Healthy Start Initiative (VHSI) includes nutrition services in its local target sites. Five of six sites have successfully hired nutritionists. VHSI's nutritionists provide intensive medical nutrition therapy to high-risk pregnant women and infants, regardless of income or insurance coverage. Nutrition services to patients are provided at private physicians' offices, hospital clinics, Early Intervention Centers and in clients' homes. The nutritionists have been involved in community-based activities partially or fully funded by Title V such as the Regional Perinatal Councils (RPC), low birth weight committees, March of Dimes folic acid education initiatives, and breastfeeding promotion initiatives.

VDH collaborated with the March of Dimes, Virginia Chapter, to broadcast radio public service announcements encouraging folic acid in women's diets for six weeks during August and September

1999. Radio stations in Richmond, Roanoke and Tidewater areas were targeted. The campaign will be repeated in August 2000.

Women's Health Virginia held its second annual conference entitled "The Dollars and $ense of Women's Health." The conference purpose was to examine economic forces affecting women's wellness through increased awareness and understanding of changes in women's health and use of health care. Because more women are being employed outside the home, providing significant economic support for their families, and combining careers with their activities as family caregivers, this focus was chosen. Business' interests in promoting women's health and the issues and costs of supporting the health of employees and their families were addressed. Costs and concerns involved in developing new treatments and health promotion programs that meet women's needs were also examined. OFHS staff served on the conference planning committee. The Division of Chronic Disease Prevention/Nutrition provided graphic design services for the conference flyer. The Virginia General Assembly allocated $35,000 for the annual event.

The contract with the University of Virginia (UVA) Medical Center to support a nurse to coordinate prenatal care services for low-income women served by the local health departments was discontinued. Many of the position duties had gradually become focused on meeting the needs of the University of Virginia Hospital and duplicating services being provided by the University Departments of Social Services and Nursing.

2.4.2.2 Children

The Virginia Fatherhood Campaign (VFC) continued to promote programs and policies that support father-presence in the lives of their children and improve the quality of fathering. The FY 99 campaign included seed grants to 12 community-based programs. These programs produced training for 710 human service workers in program development and evaluation; a media campaign, including 40 billboards, 60 interior/exterior transit bus signs, and video displays at Tidewater region 7-Eleven convenience stores; a resource center for literature and technical assistance; and on-site consultation.

Targeting Hispanics and African Americans, two new brochures entitled "Being a Father: What's It All About" and "Creating a Father-Friendly Workplace" were developed. VDH collaborated with the Department of Social Services (DSS), Division of Child Support Enforcement Services, to organize a two-day statewide fatherhood conference in May 1999. There were 250 participants, and the conference attracted considerable media attention. The number of calls to the Virginia Fatherhood Campaign Resource Center increased from 523 in FY 98 to approximately 600 in FY 99. This, however, is below the related performance measure *SPM#4: Number of calls received by the VDH Virginia Fatherhood Campaign Resource Center*.

In cooperation with the Comprehensive Health Investment Project of Virginia (CHIP), Title V funding was provided to CHIP sites in the Thomas Jefferson, Cumberland Plateau, Mount Rogers, Richmond City, and Chesapeake health districts. These programs, modeled after the CHIP of Roanoke, provided medical/social case management for families with children up to 6 years of age and worked to ensure that children have a primary care provider. According to CHIP of Virginia evaluation data, within one year after enrollment 90 percent of program participants had a private physician and 90 percent were fully immunized.

The Resource Mothers Program continued to provide lay home visiting services to pregnant and parenting teens in 80 localities. The 28 program sites provided home visiting services for 1,488 clients to encourage them to keep medical appointments and to avoid harmful health behaviors such as smoking and drinking. The Virginia Resource Mothers program sites were encouraged to develop male mentors for the fathers of the infants, or to collaborate with existing fatherhood projects in their communities. Male mentors will now be known as resource fathers. At the spring conference Minnesota Early Learning Design provided training on fatherhood involvement. Program outcome data compare program participants with pregnant women of the same age and residency. In FY 98 Resource Mothers Program participants had fewer low birth-weight babies and lower infant death rates than nonparticipants (4.7 versus 7.5 rate of infant deaths per 1,000 births). A higher percentage of program participants returned to school/work/ training (84 versus 60 percent) and delayed repeat pregnancies (94.5 versus 70-75 percent).

CHIP and Resource Mothers addressed *SPM#2: The proportion of children and adolescents who have a specific source of ongoing primary care for coordination of their preventive and episodic health care.* In FY 99, an estimated 75 percent of all children had a usual source of primary health care. The decrease from 82 percent in 1996 may reflect the difference in survey questions used to monitor this measure, as described in the note for Form 11.

During 1998 an estimated 80 percent of the two-year-olds were current on their immunizations, meeting *CPM#5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.* CHIP, Case Management/Baby Care, Resource Mothers, and well-child clinics are Title V strategies for increasing immunization rates.

2.4.2.3 Children with Special Health Care Needs

The CSHCN program maintained cooperation and coordination with the local health departments in their responsibilities for case finding and local care coordination of medical follow-up for CSS and CDC patients and participation in the IDEA-Part C service system. Other enabling activities included continued funding for Spanish interpreter services in Northern Virginia CSS clinics and providing identification and referral service from CSS and CDC programs to early childhood development programs such as Head Start and IDEA-Part C. A statewide survey found 71 percent *of Children with Special Health Care Needs (CSHCN) have a "medical/health home" CPM#3.*

2.4.3 Population-based

2.4.3.1 Women and Infants

The Newborn Screening Program screened 96,224 infants in calendar year 1998. Genetics testing screens for seven conditions, which include Phenylketonuria (PKU), Hypothyroidism, Maple Syrup Urine Disease, homocystinuria, galactosemia, biotinidase deficiency and sickle cell diseases. *CPM # 4 Percent of newborns in the State with at least one screening for each* of the above mentioned was met in FY 99.

In 1998, 60.3 percent of mothers were breastfeeding at hospital discharge. The MCH Block Grant supported numerous efforts encouraging mothers to breastfeed their infants and working towards *CPM#9: Percentage of mothers who breastfeed their infants at hospital discharge* although the 1998 figure was short of the target. Education of health care professionals was a crucial activity conducted to increase breastfeeding rates with the most effective tools being the "Basic Steps Bring Success" breastfeeding pocket guides, a newly revised Virginia's Breastfeeding Resource Guide, and The Virginia Breastfeeding Update, a biannual newsletter, published and distributed to pediatricians statewide. Public support of breastfeeding is generated through paid television advertisements throughout Virginia that address barriers to breastfeeding, such as inadequate support, lack of time, and employment outside of the home. Other strategies to increase public acceptance of breastfeeding included the annual "Mom and Baby Breastfeeding Station", August recognized by the Governor as "Virginia's Breastfeeding Awareness Month", and the Breastfeeding Task Force exhibit displayed at conferences, malls, libraries, and health fairs. In addition, enabling and population-based programs including Case Management/Baby Care, Resource Mothers, VHSI, and WIC continued to encourage breastfeeding.

In the area of public health nutrition, VDH's folic acid display has been used at four education events for both professionals and consumers. The VDH folic acid brochure has been revised and translated into Spanish to meet the needs of the growing Hispanic population. Both versions have been printed and are being used by local health department family planning, prenatal, and WIC clinics. VDH continues to represent the Association of State & Territorial Public Health Nutrition Directors (ASTPHND) on the National Council on Folic Acid. VDH printed the National Council's brochure and poster for

dissemination to physicians' offices. VDH and the March of Dimes, Virginia Chapter, established the Virginia Council on Folic Acid in October 1999. The Council will act as the steering committee for the state's folic acid education initiatives. These activities address SPM #8: *Rate of neural tube birth defects among live births in Virginia*. In 1998, neural tube birth defects were identified in 58 infants or 6.2 per 10,000 live births. As noted in the footnotes to the performance measure on neural tube defects, the same codes are now being used to collect data for all years. However, the data is still preliminary because only 94 percent have been successfully matched with birth certificates (this data is often not accurate and underreported) and quality assurance efforts are still underway to make sure defects are accurately identified in hospital records. It is hoped, however, that the drop in the rate of neural tube defects in the last year reflects the effects of the folic acid campaign undertaken in Virginia. After this data is finalized and data is collected in future years, the reason for the decline will become clearer and may be reported with greater confidence. The selection of codes to determine the rate of neural tube defects and obtaining accuracy in this data is an issue states are grappling with nationally.

VDH, DSS, and the Office of the Secretary of Health and Human Resources jointly established the Partners in Prevention (PIP) initiative to reduce nonmarital births in 1997. Following a May 1999 Request for Proposals (RFP), PIP activities, which include community-based direct services, education, and media campaigns, continued through the awarding of $1,000,000 of TANF funds allocated by the General Assembly for FY 00. Seventeen coalitions representing 48 Virginia communities received funding for programs with a newly required emphasis on those aged 20-29 who had the majority of Virginia's nonmarital births (55.4 percent in 1998). A newly hired PIP program manager disseminated 1998 nonmarital birth data to coalitions for program planning and community awareness. PIP continued promotion of waiting until marriage to conceive a child, abstinence until marriage, male responsibility, and healthy relationships avoiding risks such as cohabitation prior to marriage.

PIP seeks to reduce nonmarital births, which numbered 28,056 in 1998, while decreasing induced terminations. This emphasis is Virginia's response to the federal welfare reform legislation's (Public Law 104-193 H. R. 3734) incentive of $100 million to be split among the top five states experiencing the largest decreases in the percent of nonmarital births without increasing induced termination rates.

The ratio of induced terminations to total live births decreased by 11.5 percent from 1997 to 1998. Virginia ranked 7th during the first of four rounds in the federal incentive program. PIP coalitions plan to continue their efforts for FY 01 towards meeting *SPM#5: Percent of nonmarital births,* however the objective was not met in 1998.

Utilizing the RPCs as their statewide consortium, the Virginia Healthy Start Initiative (VHSI) received initial funding in 1997 for six target sites to reduce infant mortality and low weight births. With recently awarded federal funds in September 1999, VHSI will add three new sites with a specific focus of reducing racial and ethnic disparities in perinatal outcomes. In all target sites, VHSI expands the Resource Mothers' Program to women aged 20-24, enhances existing nutrition services to high-risk pregnant women and infants, supports Fetal Infant and Mortality Review (FIMR) programs, and provides mentoring services to fathers in their role in childbearing and parenting.

In June 1999, VHSI officially unveiled the new Loving Steps name, logo and communications materials through local kick offs led by the State Commissioner of Health. The Loving Steps campaign strives to raise awareness of how everyone, including family, friends, and community members, can influence the health of babies by encouraging pregnant women to seek early prenatal care and by helping them get needed care. The campaign's logo, a series of three footprints from birth to age one, symbolizes the growth of a healthy child, as well as the steps an expectant mother and her supporters can take to improve that child's health. The logo and campaign messages will be seen on posters, billboards, bus ads and specialty items such as bibs, tote bags, caps and pens that will be used to raise awareness in the target communities. Through the campaign, Healthy Start will seek to increase community awareness of the medical, behavioral, emotional and social needs of women and infants; streamline and coordinate services between public and private agencies; and encourage commitments to good prenatal care among families, volunteers, businesses, and health care and social services providers.

In addition to the promotional campaign, Loving Steps seeks to improve prenatal and infant health through several existing VDH/Title V programs. The Loving Steps partners include the Resource

Mothers and Resource Fathers Program, the VFC, the FIMR program, Nutrition Services and the RPCs.

2.4.3.2 Children

The teen birth rate continued to decrease, from 25.9 in 1997 to 24.1 in 1998, meeting the objective for *CPM#6: The birth rate (per 1,000) for teenagers aged 15 through 17 years*. Funding continued for the 18 existing Better Beginnings Coalitions through June 30 to increase awareness and develop community approaches to the prevention of teen pregnancy through youth development, media, and other strategies. Better Beginnings Coalitions sponsored a variety of local activities to recognize Let's Talk Month and Teen Pregnancy Prevention Month. Nineteen communities were selected through an RFP for funding beginning July 1, 1999.

In addition, Title V staff monitored, provided guidance, and coordinated evaluation for Teenage Pregnancy Prevention Programs in the seven health districts of Richmond, Alexandria, Norfolk, Roanoke, Portsmouth, Crater, and the Eastern Shore. The Teenage Pregnancy Prevention Programs implemented collaborative community plans that included both public awareness and direct youth programming to reduce sexual activity and teen pregnancy. Working with its Office of Health Policy, VDH contracted with VCU-SERL to provide local site evaluation studies of four of the sites. A fifth site contracted with an independent evaluation specialist. Evaluation findings are available in the annual legislative report, "Evaluation of the VDH Teen Pregnancy Prevention Initiative."

In FY 99 the Title V program supported a number of activities targeting SPM*#9: Percent of children who have healthy weights.* A series of brochures that address childhood obesity were developed for low-income parents of preschoolers. Training was conducted for day care providers statewide on nutrition for preschoolers. In addition, nutrition consultation was provided to the Head Start Health Advisory Board, including distribution of materials on healthy weight for children. Nutrition education materials were distributed to elementary school teachers for National Nutrition Month. A 1997 survey

found that approximately 33 percent of 4th grade students were overweight. A repeat survey to monitor this objective is planned for FY 00.

The Virginia Osteoporosis Coalition, including Title V staff, continued to collaborate with the Department of Education (DOE) on activities for children. Coalition members participated in "DOE's Hour" on cable television. The one-hour teacher training included an overview of osteoporosis and how education of children can help prevent the disease in later years. Coalition members also demonstrated activities designed for classroom replication.

The Title V program hosted quarterly meetings of the Virginia Coalition for Childhood Injury Prevention and funded a variety of public education activities to prevent unintentional injuries. Six health districts were given funds for community-based injury prevention activities to support home, fire, and playground safety. To promote playground safety, program staff coordinated a Playground Safety Demonstration project in collaboration with the DOE. The Virginia SAFE Playgrounds committee, disseminated updated playground safety information to all elementary schools, and distributed a playground safety video to schools and day care providers. Richmond, Hampton, and Wise County were provided funding and technical support to pilot *Risk Watch*, an injury prevention curriculum for schools through the DOE. To promote water safety, the program coordinated a state water safety coalition, developed a water safety event planner and provided funds to 12 community groups across the state to support water safety events. To emphasize product safety, the program disseminated product safety releases and promoted the Annual Recall Round-Up.

Staff worked closely with the DSS, Day Care Licensing and Training Division to provide safety materials and training across Virginia. Staff also served on the DSS Head Start Health Advisory Committee to provide safety updates and information. Seasonal press releases promoted these and other childhood injury prevention messages. The PHHS Block Grant, a CDC Smoke Detector Installation and Education Grant, a highway safety grant, and state revenue funds also supported additional OFHS' childhood injury prevention activities that have not been detailed in this report. The FY 98 data are not yet available for *SPM#6: The unintentional injury hospitalization rate for children aged 1-14 per 100,000.*

FY 98 data are not yet available for *SPM#7: The incidence of assault injury hospitalizations among people aged 10-19*. This objective was supported through staff participation in planning of the Adolescents At Risk: Second Chance Program at MCV Hospitals, a program which pairs firearm injured youth with mentors. Local health departments and middle and elementary schools across Virginia disseminated over a quarter million parent brochures on youth violence prevention to parents. Extensive state and local sexual assault prevention efforts are funded through a CDC Violence Against Women Grant. State Systems Development Initiative (SSDI) funding supported conducting a statewide youth violence needs assessment, press releases on violence prevention, and distribution of over 4,000 summary reports to schools and other stakeholder groups in Virginia. Staff supported through other funds also provided violence prevention education, resources and referral, data analysis and reporting.

VDH strategies to promote motor vehicle safety were funded through the Department of Motor Vehicles from a federal highway safety grant and did not use Title V funds. The FY 98 objective was not met for CPM*#8: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.* The rate increased from 3.7 (deaths per 100,000 children aged 1-14) in 1997 to 4.2 in 1998.

2.4.3.3 Children with Special Health Care Needs

Population-based services for children with special health care needs were provided through several infant identification and tracking programs. The Newborn Screening Program screens all newborns for metabolic and sickle cell diseases and provides follow-up testing and referral. Virginia Congenital Anomalies Reporting and Education System (VaCARES) is a congenital anomalies registry. The Virginia Hearing Impairment Identification Monitoring System (VAHIIMS) is an identification and monitoring system for infants at risk for hearing loss. The High Priority Infant Tracking Program (HPITP) was a pilot identification and tracking system for high-risk infants that is linked to the Child Find component of IDEA Part H/C.

VaCARES continued collecting information on all resident infants and children up to age 2 who were diagnosed with a congenital anomaly at Virginia hospitals. Identified families received basic information on VaCARES including a VDH managed toll-free number to obtain referrals and support service information. In FY 99, work continued to finalize a 1991-95 aggregate report on Virginia children diagnosed with anomalies.

In 1998 Virginia enacted legislation mandating that all newborns receive a hearing screening prior to hospital discharge effective July 1, 2000. During FY 99 a multidisciplinary statewide Advisory Committee held four meetings and assisted in the design, implementation, and revision of the Virginia Hearing Impairment Identification Monitoring System (VAHIIMS). The Title V program provided support for a one-day workshop for hospitals and audiologists on newborn screening and follow-up, developed and trained hospitals in the use of a new electronic reporting system and database, developed and disseminated newborn hearing screening protocols to all hospitals, developed and disseminated protocols for diagnostic audiological assessment to all licensed providers and all known facilities providing services, developed and initiated a process for approval of practitioners/facilities capable of providing diagnostic audiologic services to infants and young children, developed and disseminated parent brochures to all hospitals, and completed the first draft of a Parent Resource Guide for children. Progress continued in the regulatory process for revising regulations for VAHIIMS. The FY 98 objective was met for *CPM#10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.* The number of births in 1999 is not yet available.

Through a contract with the Division of Child and Adolescent Health (DCAH), the Center for Pediatric Research (CPR) at Eastern Virginia Medical Center (EVMS), studied the predictive value of criteria to identify high-risk infants at birth. CPR also began an analysis of referrals and outcomes for infants served by the HPITP. In addition, CPR assessed the feasibility of using hospital discharge data for high-risk infant identification and developed a concept paper for the design and implementation of an integrated infant tracking system using a web-based infant registry. The first phase of the web-based registry, for newborn hearing screening (Test Our Newborn's Ears, or TONE) is complete. The HPITP

was discontinued at the end of the fiscal year with the intent to develop a new web-based system centered on TONE.

2.4.4 Infrastructure

2.4.4.1 Women and Infants

The OFHS Division of Women's and Infants' Health (DWIH) continued to provide policy and procedural oversight concerning women's and infants' health services. This included the monitoring of data related to low birth weights, infant mortality, women's and infants' health issues, and access to and utilization of prenatal care. DWIH also provided procedural oversight and leadership for the RPCs and the VHSI.

DWIH was awarded a $1,000,000 per year federal Healthy Start Initiative grant in September 1999 to enhance three communities' service systems in Alexandria, Lynchburg, and Pittsylvania/ Danville with the goal of reducing racial and ethnic disparities in perinatal health. These communities were chosen due to their existing wide disparities. VHSI (Phase II) proposes to address the racial disparity of maternal and child health outcomes by enhancing existing services as well as initiating new services as discussed under Enabling Services.

Seven Regional Perinatal Councils (RPCs), created in 1992, continued working to improve perinatal health delivery system throughout the state. Their efforts include fostering a collaborative network among perinatal service providers with the ultimate goal of providing risk appropriate care to all Virginia perinatal clients. Through contractual arrangements administered by DWIH, Title V funded the seven RPCs to assist in the development and maintenance of community level infrastructure necessary to support prenatal service delivery. During FY 99 RPC activities focused on access to care, standards of care, low weight births, infant mortality and other relevant regional issues including maternal transport, cultural competency among service providers, and perinatal substance abuse issues.

Each RPC conducted a manpower survey in 1999 to identify all perinatal providers and their hours and locations of service. The results were used to identify perinatal underserved areas in the state. The completed report, *Perinatal Underserved Areas in Virginia, 1999,* will be published and distributed to perinatal stakeholders in FY 01.

In FY 99, Region 1 continued with their folic acid public awareness campaign. An evaluation of the campaign showing increased knowledge, awareness, and behavior changes was published in CDC's *Morbidity and Mortality Weekly Review* on October 14, 1999. Region 2 received additional March of Dimes funding to identify regional low weight birth high-risk factors through conducting in-depth interviews with affected mothers. Working with the local ASSIST coalition, Region 3 conducted a smoking cessation project including a media campaign with billboards and brochure distribution. In cooperation with the state campaign, Region 4 ran a major folic acid awareness campaign with radio and television spots. Region 5 helped translate health materials into foreign languages to help meet needs of the growing multicultural population. A mini-version of medical records, the prenatal "passport" was developed and implemented in Region 6 for pregnant mothers to carry pertinent health information. This region also worked to revise the referral system for high-risk mothers and at-risk infants following intensive care unit stays. In Region 7, a questionnaire was conducted on women not having any prenatal care. Study results are currently being prepared.

RPCs also assess, support, and provide professional education services to improve perinatal services and ensure that providers remain current in knowledge needed to serve high-risk pregnant women. In FY 99, the RPCs provided 1,178 professional education hours on more than 100 perinatal topics attended by over 8,032 health professionals.

A growing and important role of RPCs is to initiate and conduct community level Fetal Infant Mortality and Review (FIMR) projects. Each RPC conducts at least one local FIMR. Fourteen FIMR programs exist statewide covering 56 Virginia localities. In FY 99, Case Review Teams (CRT) examined 205 cases. Each FIMR has identified or formed a Community Action Team (CAT) responsible for implementing recommendations.

Local FIMRs disseminated client education materials and promoted public awareness campaigns including "Back to Sleep", "Kicks Count", "Babies and You", and "Baby Think Ahead". FIMRs provided education to private providers on the importance of prenatal risk screening for all mothers, the VHSI program, FIMR, and other local resources. They initiated the development of perinatal bereavement protocols and standards of care. Advocating for outreach education regarding the need for early prenatal care and risks of birth defects, FIMRs targeted the foreign-born population, especially Middle Easterners and Hispanics. FIMR activities included piloting a home visiting program for grief counseling. A statewide infant mortality summit, held in June 1999, brought together 99 participants from the public and private sectors to encourage community collaboration. As an example of effective community partnerships, Virginia's FIMR has been requested to present at the national conference, "Partnerships for Health in the New Millennium: Launching Healthy People 2010".

The Acting Statewide SIDS Program Manager, a contractor, continued to convene the quarterly meetings of the SIDS Notification and Referral Committee after the resignation of DWIH's Neonatal Nurse Consultant. This contractor also serves on the Training and Education Committee of the National SIDS and Infant Death Program Support Center.

After reviewing materials used by the ME's office for SIDS notification to families, the Committee made recommendations, which were subsequently implemented, to standardize materials and improve the appropriateness of these materials. The notification and referral system continues to be conducted through regional coordinators and local health departments. In 1998, family bereavement support referrals were made for 56 SIDS infant death cases and successful contacts were made in 41 cases. The committee is presently advising DWIH on revisions for the SIDS web page.

All RPCs distribute Back to Sleep materials throughout the year. With VHSI funding, a large reprinting occurred and was distributed in 6 VHSI target sites. Regions 3 and 6 each conducted local public awareness campaigns. Northern Virginia (5) is partnering with the March of Dimes to conduct a "Safe

Sleeping" campaign during FY 00. Governor Gilmore recognized October 1999 as Sudden Infant Death Syndrome Awareness Month in Virginia.

RPC's activities as well as the enabling services of Resource Mothers, VHSI, and Case Management/Baby Care, address *CPM#15: Percent of very low birth weight live births; CPM#17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates; and CPM#18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*.

To further develop and effectively utilize perinatal service delivery infrastructure, DWIH has teamed with the Virginia Chapter of the American College of Nurse Midwives (ACNM) under a special grant from the American College of Nurse Midwives and the MCH Bureau. *Collaborating for Results,* a one-day meeting in September 1999, brought together perinatal providers from a diverse group of organizations. Their dialogue centered on how stakeholders can work together to share care and maximize resources. The ultimate goal is to improve the quality and availability of care for women and their babies, particularly those who are poor, live in underserved areas, and are at risk for infant death and disabilities. Discussions addressed objectives of educating providers about the myths and realities of collaborative practice, teaching how to create or expand shared care in current practices for the benefit of patients, helping providers use VDH resources, and developing a mechanism to sustain ongoing, collaborative dialogue among all perinatal providers. Virginia Chapter ACNM and Virginia Academy of Family Physicians representatives will deliver a workshop on shared care and how it can be profitable at the annual meeting of family physicians.

In FY 99, the Genetics Advisory Board and its subcommittees met biannually. Preliminary work to determine the feasibility of adding Congenital Adrenal Hyperplasia to the current battery of newborn screening tests has been done by Genetics Program Staff and the Board, including the Hypothyroid subcommittee. The study team is developing a uniform survey to solicit more input from families through interviews. A final report will be submitted to the Virginia General Assembly in 2001 as mandated by SB

699. This will include an examination of issues, costs, and benefits of testing as well as final recommendations.

DWIH contracted with the Medical College of Virginia, Adult and Sickle Cell Programs and the Virginia Sickle Cell Awareness Program (VASCAP) to provide a regional conference on Case Management in Sickle Cell Disease in April 1999. The objectives were to understand the patho-physiology and psychosocial impact of sickle cell disease, the current medical management of severe complications, current trends in research, the role of nursing in both acute and long-term management, and the possible affects of managed care. Attendance numbered 77 participants.

2.4.4.2. Children

The Division of Child and Adolescent Health continued to provide policy and procedural oversight concerning children's health services. These activities included monitoring and reporting data and program oversight for child health, including children with special health care needs, lead poisoning prevention, the Abstinence Education Initiative, and access to health care services.

In FY 99, an estimated 10 percent of Virginia children were uninsured. While this is a decrease over the FY 96 estimate, it does not meet the performance objective for *CPM#12: Percent of children without health insurance*. One reason is that enrollment in the Children's Medical Security Insurance Plan (CMSIP/Title XXI) was slower than anticipated. The 1999 estimate comes from a statewide children's health access survey, a collaborative project of VDH and DMAS under Title V program leadership. CMSIP application forms and referral counseling were made available in local health departments and WIC and CSHCN clinics. Health departments collaborated with other community partners to increase awareness and encourage application and enrollment in CMSIP. Many participated in CMSIP Awareness Day, a statewide activity designed to heighten local awareness, provide greater accessibility, and facilitate community partnerships around the local CMSIP outreach efforts. VDH staff worked closely with the DSS in CMSIP material coordination and distribution.

VDH outreach strategies included integration of CMSIP outreach within existing programs which serve children.

Well child clinics encourage and Children's Specialty Services (CSS) require that all potentially eligible patients apply for Medicaid and CMSIP. In FY 99, 66 percent of the CSHCN program participants were covered by Medicaid, approximately the same as in FY 98. This activity, in addition to outreach for CMSIP and case management services, address *CPM#13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program.* Outreach for CMSIP has identified many Medicaid-eligible children in the general population. An estimated 87 percent of Medicaid eligible children were documented as receiving a service paid by Medicaid in FY 99. The substantial increase over FY 98 reflects a revised accounting methodology by the Department of Medical Assistance Services.

The teen suicide rate remained the same from 1997 to 1998, which met *CPM#16: The rate (per 100,000) of suicide deaths among youths 15-19.* Title V funds continued to support a State Child Fatality Review Team coordinator, housed in the Office of the Chief Medical Examiner. The team began a study of youth suicides, which was completed in FY 00. Under the Center for Injury and Violence Prevention's (CIVP) leadership, Title V staff assisted with a study of suicide in response to Senate Joint Resolution 382. The findings include recommendations for suicide prevention among youth.

Participation continued with Healthy Child Care Virginia (a CISS project) and the Head Start Collaboration Project. The Early Childhood Task Team developed a packet of health-related brochures, information, and resources available to child care providers through the statewide network of 27 Child Care Resource and Referral Centers. A Memorandum of Agreement (MOA) was developed with the DSS to fund a nutrition assessment, provide materials to the Child Care Resource and Referral Centers, and fund a nurse practitioner at VDH to serve as Health and Safety Child Care Coordinator. This position will be filled in FY 00.

The Title V program continued its partnership with the Department of Education (DOE) to support school health. A school nursing services survey was developed and administered to all school divisions. Three meetings were held with school division health services representatives for presentations and updates. The 1996-97 School Health Advisory Boards Summary was completed and submitted to DOE for publication. Training guidelines were developed for administration of glucagon and insulin to students, pursuant to new legislation. The 2nd edition of *Virginia School Health Guidelines*, 1999, was completed. DOE funded printing of the manual and sent one to each public and accredited private school and health district. The *School Entrance Health Form* was revised and distributed to health districts, school divisions, and day care centers. The School Nurse Institute Partnership coordinated and offered continuing education throughout Virginia and developed a web site. In addition, VDH provided ongoing assistance in the research and development aspects of *Welligent*, a web-based school health management software program that is based on the School Health Information System prototype and being implemented in Virginia school divisions.

VDH staff helped plan a human services conference, "Moving in the Right Direction: Tying It All Together" sponsored by the DSS, including preconference sessions on adolescent health and fatherhood held May 17 and 18 in Virginia Beach. Over 25 sessions on adolescent health provided a forum for diverse human services staff to discuss health and development issues for the youth in Virginia.

The Center for Pediatric Research at EVMS completed its study of pediatric health care funded by Title V. The study concluded that indicators to monitor the quality of pediatric care in Virginia should include pediatric medical and economic access, the quality of pediatric outcomes, and the impact that specific interventions may have on enhancing individuals propensity to seek care.

OFHS staff continued to provide consultation and technical assistance to local health departments and other public/private agencies for obtaining, analyzing and using child health data. The OFHS School-Age Population Task Team initiated a project to collect and publish a snapshot of the health of youth aged 5-22 using available quantitative data.

2.4.4.3 Children with Special Health Care Needs

The Children with Special Health Care Needs Program within the Division of Child and Adolescent Health provided policy and procedural oversight concerning CSHCN services. Activities focused on systems development for this population.

The FY 99 objective was met for *SPM#1: Enhance the statewide network of comprehensive, community-based health care systems that serves children with special health care needs to assure family-centered, culturally competent, and coordinated services***.** The CSHCN Program conducted a statewide assessment of the needs of and the service system for children with chronic physical conditions and completed a report that includes recommendations for improvements in the broad system of care for CSHCN. A marketing plan and materials were developed that included forums in four areas of the state. In the course of marketing the recommendations, concerns were expressed about some of the proposed changes. An internal strategic planning committee is conducting further analysis before moving forward with any recommendations for changing the delivery system.

Three parents of children who have hearing loss served on the VAHIIMS Advisory Committee. Parents continued to serve on the CSHCN Advisory Task Force and the steering committee for the CSHCN study. The needs assessment component of the study included a written survey and focus groups of parents of CSHCN. No additional characteristics of family participation were achieved, as measured by the scale for *CPM#14*: The *degree to which the State assures family participation in program and policy activities in the State CSHCN program.*

In FY 99 the CSHCN Program achieved an increase to 87 percent for *CPM#11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.* Children's Specialty Services continued to be a Medicaid service provider and became a CMSIP provider. However, the CSHCN Program was not successful in enrolling CSS and CDC programs as providers in Medicaid HMO plans. CSHCN staff collaborated with DMAS in a review of Medicaid coverage of medical nutrition therapy for children with special

health care needs. The study recommended that medical nutrition therapy be added to the State Medicaid Plan.

Division of Child and Adolescent Health and local health department staff participated at the state and local levels in the IDEA-Part C program, the Comprehensive Services for At-Risk Youth and Families (CSA), Emergency Medical Services for Children, and other interagency systems building initiatives to expand and enhance community services for CSHCN. Child Development Clinic staff provided ongoing training and technical assistance to Head Start, primary pediatric health care providers, public health nurses, child care providers, school staff, and others on developmental screening and care planning.

The Title V program representative chaired the IDEA-Part C Early Intervention Interagency Management Team and participated on several committees. The Ability-to-Pay subgroup gathered information from localities on what families are paying per visit for early intervention services. The Monitoring and Improvement Measurement System task force made site visits to local coordinating councils to pilot the review process. Staff helped develop a RFP to evaluate the Part-C system. The Title V program representative served as secretary and acting chair of the CSA State Management Team, liaison to the State Executive Council, member of the Training/Technical Assistance Work Group, and member of a committee to develop a new policy on local CSA multidisciplinary teams and a reporting form.

Title V staff continued to provide leadership to the Virginia Asthma Coalition. The coalition established subcommittees on educator certification, policy development, data needs, and planning for a statewide summit. About 75 physicians, nurses, health planners, managed care representatives, and legislators attended the October 1999 summit. These proceedings will provide the basis for a state action plan to address asthma.

2.4.4.4 Other Activities

To better fulfill its recently augmented mission of assessment, quality assurance, and policy development, OFHS created a new position for a managed care policy analyst in August 1999 funded by Title V. As leader of the OFHS Managed Care Team, the analyst has responsibility for researching and analyzing state and federal legislation as well as public and private accreditation and reporting requirements affecting managed care in Virginia and the impact for Title V populations. The analyst coordinates VDH efforts to review the State Medicaid Plan and managed care contracts and waivers to ensure MCH population issues are addressed. Researching and promoting best practices for CSHCN also represents an area of job responsibility. This person is the VDH liaison with Department of Medical Assistance Service (DMAS) and the Center for Health Care Quality and Consumer Protection (CHCQP) for issues of managed care and quality assurance.

Other efforts to build infrastructure related to assessment data include maintenance and development of relationships with academic institutions. The Eastern Virginia Medical School Center for Pediatric Research (EVMS-CPR) and the Virginia Commonwealth University Survey and Evaluation Research Laboratory (VCU-SERL) both provided evaluative services and conducted studies under various program contracts. In addition, the Virginia Abstinence Initiative established an evaluation consortium of professionals from numerous academic institutions in its evaluation plan. OFHS continued to collaborate with Virginia Health Information (VHI) to maintain access to the statewide hospitalization database.

The toll-free MCH Help Line services were provided through an agreement with the DSS' Statewide Human Services Information and Referral System. During FY 99, 18,278 calls regarding maternal and child health services were received. OFHS and the DSS have continued heightened efforts to identify community referral resources, determine reporting data, and market the help line. These efforts over the past two fiscal years appear to have promoted increased utilization, as the number of calls increased 100 percent between FY 97 and FY 99.

Many of the additional OFHS activities in FY 99 focused on infrastructure building. These activities included policy development, data collection and monitoring, information systems development, and training

to provide culturally competent systems of care. Title V staff provided analysis and recommendations to the governor on legislation before the General Assembly that directly affected VDH programs and women's and children's health in Virginia. They also continued to review and comment on legislation, regulations, and standards of other state agencies from a maternal and child health perspective.

The MultiCultural Health Task Force (MCHTF) developed a survey that was utilized to identify and describe some of the successes, best practices and problems public health providers encounter when delivering services to multicultural populations as part of phase I of its Multicultural Health Research Initiative. The survey queried information regarding service provider's knowledge, resources, staffing, organizational policy and procedures, and community outreach to serve multicultural populations. As part of Phase I all VDH health Districts were surveyed in addition to VDH's Children with Special Health Care Needs Program, Sexual Assault Program, Community Health Centers and VDH Dental Program. From this research the MCHTF developed a series of recommendations to improve services for these populations. These encompass needs to establish links, educate, and communicate with relevant community-based networks, religious organizations, and local leaders. Training and translated materials identification and promotion were included. Policy development, program design and evaluation marked other areas with recommendations to include multicultural components with target group participation encouraged. Survey results and recommendations are reported in three separate recently released reports.

2.5 Progress on Outcome Measures

(See Form 12, Section 5.8)

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

Virginia's Title V Needs Assessment for FY 01 encompassed compilation and analysis of various quantitative and qualitative data sources. The OFHS Management Team organized and led the assessment process with each Team member gathering information and soliciting feedback from their respective divisions. In addition, the newly created Family and Community Health Advisory Committee also reviewed data and provided input for the assessment. Members on this committee come from a variety of geographical areas around the Commonwealth and represent various health and community organizations and families. Key stakeholders and the public had the opportunity to help identify priority needs through the public comment period.

Promoting efficiency and avoiding duplication of efforts, the process started with collection and analysis of recent needs assessments, which have been conducted for Title V and other OFHS programs. In the past five years, comprehensive needs assessments have been completed for the Center for Injury and Violence Prevention (1999), Children with Special Health Care Needs Program (1999), Dental Health Program (2000, in final stages), and Family Planning Program (1999). Academic institutions and other professional research specialists were contracted in these projects. The assessment for the Children with Special Health Care Needs Program elicited significant family involvement. Assessments performed through other agencies serving maternal and child health populations, such as the Department of Social Services and the March of Dimes were reviewed for pertinent data.

In addition, research on various maternal and child health issues has been conducted or sponsored through Title V and other OFHS programs. The MultiCultural Health Task Force directed a research initiative, which included surveys and focus groups with consumers and providers. These efforts covered Dental, Children with Special Health Care Needs, Sexual Assault, and overall local health department program issues faced in serving growing multicultural populations. The Division of Women's and Infants' Health, in conjunction with the Regional Perinatal Councils, collected manpower data statewide in 1999 on public and private sector perinatal providers and designated underserved jurisdictions. This report, *Perinatal Underserved Areas in Virginia*, 1999 also included perinatal indicators and outcomes analyzed by perinatal regions for 1993-97. The Division of Child and Adolescent Health, in partnership

with the Department of Medical Assistance Services, sponsored the 1999 Virginia Children's Health Access Survey conducted by the Virginia Commonwealth University, Survey and Evaluation Research Laboratory. This telephone survey performed in Spring 1999 provided data on children's health status, access to and utilization of health care services, insurance status and demographics. These data will serve as baselines in monitoring the growth and impact of the Children's Medical Security Insurance Plan (CMSIP).

Annual surveys, such as the Virginia Behavioral Risk Factor Surveillance System (BRFSS) were also utilized. The 1999 BRFSS included modules on folic acid intake, health care utilization, and insurance status. Legislative studies, including some conducted by the Virginia Joint Legislative Audit and Review Commission, which covered timely issues such as welfare reform were incorporated. Specific mortality reviews by the State Child Fatality Review Team examined all suicide (1994-95) and firearm (1995) deaths. These findings have also been presented within the context of the assessment.

Further quantitative data were gathered from several sources. Birth and death data originate from the Virginia Center for Health Statistics. Special runs for indicators and outcomes by race and ethnicity, payment source, and mandated Medicaid managed care areas were executed for this assessment. Hospitalization data were accessed through a state database managed by the Virginia Health Information and shared under a collaborative agreement with the VDH. VDH's Office of Information Management also pulled patient program data for analysis. Data cited largely reflect the most recent five years worth of information which was generally 1994-98. A five-year span was chosen since the last assessment was performed in FY 96. Because some publications cited were completed in the previous year or two, some data may be for earlier years or varying time blocks. Data for 1999 were included when available.

Qualitative data from focus groups were examined through several efforts conducted by the Division of Child and Adolescent Health, Division of Women's and Infants' Health, and the MultiCultural Health Task Force. Consumers participating included adolescents, low income African Americans residing in public housing, multicultural populations, and families of children with special health care needs. Further

public input for the needs assessment was gathered through the Family and Community Health Advisory Committee, the OFHS website which posted the assessment for public comment, and program manager feedback from community-based groups working with VDH programs. Key stakeholders, including local health districts, were also notified of the pending application and requested to review the findings through a web-based draft. Throughout the process the OFHS Management Team continued to lead and facilitate identification and prioritization of need through data analysis and public and key stakeholder input. Table 1 lists all data sources, research projects, and assessments utilized for the FY 01 Title V Needs Assessment.

Table 1: Title V Needs Assessment Research

RESEARCH/ASSESSMENT	TYPE OF DATA	AGENCY/SOURCE OF REPORT
Needs Assessments:		
Services for Children With Special Health Care Needs and Their Families: Virginia 1999 Needs Assessment and Recommendations (1999)	Surveys, Focus Groups, Key Informant Interviews, Data Analysis	Health Systems Research, Inc. contracted by Division of Child and Adolescent Health, Virginia Department of Health
Title X: Family Planning Needs Assessment (1999)	Data Analysis, Key Informant Interviews	Division of Women's and Infants' Health, Virginia Department of Health
Youth Violence Prevention in Virginia: A Needs Assessment (1999)	Data Analysis, Program Review	Curry School of Education, University of Virginia contracted by Center for Injury and Violence Prevention, Virginia Department of Health
Perinatal Needs Assessment	Data Analysis	March of Dimes, Virginia Chapter
Special Research Projects:		
Cultural Competency in Public Health: Meeting the Needs of Virginia's Multicultural Populations (2000)	Surveys, Data Analysis	MultiCultural Health Task Force, Virginia Department of Health
Suicide Fatalities Among Children and Adolescents in Virginia 1994-95 (2000)	Data Analysis (Case Review)	State Child Fatality Review Team, Office of Chief Medical Examiner, Virginia Department of Health
Childhood Injury in Virginia: A Report on Injury-Related Deaths and Hospitalizations Among Children and Adolescents in Virginia , Ages 0-19, 1994-1997 (1999)	Data Analysis	Center for Injury and Violence Prevention, Virginia Department of Health
1999 Virginia Children's Health	Telephone Survey	Virginia Commonwealth University, Survey and

Access Survey	Data on Children's Health Care Utilization/ Insurance	Evaluation Research Laboratory contracted by Virginia Department of Health and Virginia Department of Medical Assistance Services
Cultural Competency in Public Health: Virginia's Response to Dental Trends and Issues among Multicultural Populations (1999)	Surveys, Data Analysis	MultiCultural Health Task Force, Virginia Department of Health
Perinatal Underserved Areas in Virginia, 1999	Surveys, Data Analysis	Regional Perinatal Councils and Division of Women's and Infants' Health, Virginia Department of Health
Summary of Health District Visits (1999)	Interviews with Health Districts	Division of Child and Adolescent Health, Virginia Department of Health
Assessing the Health Needs of Unique Populations of Adolescents in Virginia (1998)	Focus Groups with Adolescents	Virginia Institute for Developmental Disabilities, Virginia Commonwealth University contracted by Division of Child and Adolescent Health, Virginia Department of Health
Child Fatalities in Virginia: 1994 (1998)	Data Analysis (Case Review)	State Child Fatality Review Team, Office of Chief Medical Examiner, Virginia Department of Health
Cultural Competency in Public Health: Virginia's Response to Children with Special Health Care Needs (1998)	Surveys, Data Analysis	MultiCultural Health Task Force, Virginia Department of Health
Reports on Prenatal Care Focus Groups (1998)	Focus Groups	Norfolk State University and Virginia State University contracted by Virginia Healthy Start Initiative, Division of Women's and Infants' Health, Virginia Department of Health
Report on the Child Nutrition Focus Group Project (1998)	Focus Groups	Division of Chronic Disease Prevention and Nutrition, Virginia Department of Health
Sexual Assault Prevention Survey (1998)	Telephone Survey	University of Virginia, contracted by the Center for Injury and Violence Prevention, Virginia Department of Health
Virginia Child Health and Immunization Survey (1998)	Household Survey	Center for Pediatric Research, Eastern Virginia Medical Center
Youth Speak Out About Their Health: Adolescent Health Needs Assessment Report (1997)	Focus Groups	Virginia Institute for Developmental Disabilities, Virginia Commonwealth University
Report on Availability of Dental Health Services (1996)	General Assembly Study	Division of Dental Health, Virginia Department of Health
Health Utilization and Access: A Profile of Children of the Commonwealth of Virginia (1994)	Telephone Survey Data on Children's Health Care Utilization/ Insurance	Virginia Commonwealth University, Survey and Evaluation Research Laboratory contracted by Virginia Department of Health and Virginia Department of Medical Assistance Services
Legislative Studies:		
A Study of Suicide in the Commonwealth (2000)		Virginia Department of Health
Report on Newborn Infants Dependent on Controlled Substance (2000)		Virginia Department of Social Services
Review of the Performance and Management of VDH (2000)		Joint Legislative Review and Audit Commission
Virginia's Welfare Reform		Joint Legislative Review and Audit Commission

Initiative: Implementation and Participant Outcomes (1999)		
Improving Access to Perinatal Care in Rural and Underserved Areas (1998)		Perinatal/Early Childhood Subcommittee of the Maternal and Child Health Council
Study of the Indigent/Uninsured Pursuant to SJR 298 (1998)		Joint Commission on Health Care

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health (MCH) Population Health Status

The overall health status of Virginia's maternal and child health population has continued to improve in the past five years as evidenced by declining mortality rates, most noted in infants and children. Deaths due to low weight births, congenital anomalies, and unintentional injuries have decreased. Many reportable infectious disease rates have also fallen as evidenced by syphilis, gonorrhea, Human Immunodeficiency Virus (HIV) infection, mumps, and chicken pox trends. Teenage pregnancy rates have reached an all time low. Health status, however, remains quite unequal with variations seen by race, income, age, insurance coverage, family structure, and residency. Outcomes have been most poor among blacks and the gap observed in benchmark indicators, such as infant mortality, has persisted. The nonmarital births have increased significantly. Many of these children will be raised in father-absent families and may not experience the unique contributions that a father may make to their development. Children living in father-absent households are much more likely to be poor, are at a higher risk of school failure and drop-out, and are more likely to engage in early sexual behavior and other self-destructive behaviors (Ooms, 1998). Two-parent families not only provide a protective factor for children's economic status and development, but families with two married parents demonstrate the highest rates of health insurance coverage and health care utilization. Unmarried mothers and their children, as well as the uninsured, have lower utilization rates of primary and preventive services. This is reflected in birth outcomes with higher rates of low weights and infant mortality in these populations.

Reduction of morbidity and mortality through healthy behavior promotion is another concern based on health status data. Continued decreases of unintentional injuries are dependent on sustained safety promotion and practices. Poor eating habits and lack of exercise have been identified as concerns in both

children and women, having multiple health implications over the lifespan. While there have been some decreases, smoking has remained at high levels. Adverse habits or behaviors, many of which are developed in childhood or early adulthood, compromise health in later years as evidenced by hypertension, heart disease, cancer, and osteoporosis. In addition, substance abuse, depression, and domestic violence remain areas difficult to adequately measure but available prevalence data and resource needs indicate these concerns also greatly impact adolescent and women's health.

Serious emotional disturbance, hearing impairment, and asthma constitute the most prevalent diagnoses affecting children defined with special health care needs. Early identification and comprehensive linkage to services remains a focus for improving health status among this population.

Overview: Pregnant Women, Mothers and Infants

In 1998, 127,551 pregnancies occurred to residents of Virginia. Of these, 94,114 (73.8 percent) resulted in a live birth. Of the 33,347 fetal deaths which occurred, 25,913 (20.3 percent) were induced terminations, while the other 7,524 (5.9 percent) were natural fetal deaths. Although the majority of pregnancies were to whites, minorities accounted for over one-third of pregnancies. The largest minority groups represented were blacks (26.6 percent), Asians (4.5 percent), and Hispanics of all races (5.8 percent). Teens accounted for 12.3 percent of all pregnancies. The largest proportion (25.8 percent) of pregnancies occurred to females aged 25-29. Four out of ten (41.3 percent) pregnancies were to unmarried females in 1998 (Virginia Center for Health Statistics).

The 1998 pregnancy rate in Virginia was 82.2 per 1,000 females aged 15-44 (Table 2). This represented the highest rate in the past four years, but remained lower than 1994 and earlier. Females aged 25-29 had the highest age-specific rate and number of pregnancies.

Table 2: Age-Specific Pregnancies and Pregnancy Outcomes, Virginia 1998

Age	Pregnancy Rate	Number of Pregnancies	Birth Rate	Number of Births	Induced Termination Rate	Number of Induced Terminations	Natural Fetal Death Rate	Number of Natural Fetal Deaths
Under 15	1.8	415	0.9	219	0.8	181	0.1	15

Ages 15-17	41.9	5,159	26.3	3,235	13.7	1,680	2.0	244
Ages 18-19	97.8	10,089	64.5	6,648	29.1	2,997	4.3	444
Ages 20-24	128.3	30,678	88.7	21,205	34.1	8,163	5.5	1,310
Ages 25-29	132.7	32,966	101.7	25,270	23.7	5,895	7.2	1,801
Ages 30-34	106.9	28,970	86.3	23,381	13.9	3,757	6.8	1,832
Ages 35-39	52.8	15,246	40.3	11,645	7.9	2,277	4.6	1,324
Ages 40-44	12.2	3,373	7.8	2,159	2.6	733	1.7	481
Ages 45 +	0.7	164	0.4	88	0.2	46	0.1	30
Unknown		491		264		184		43
Total	82.2	127,551	60.7	94,114	16.7	25,913	4.9	7,524

Source Data: Virginia Center for Health Statistics

Resident live births in 1998 represented an increase from the previous three years (Table 3, next page). Over one-third of all 1998 infants born were of minority status, including Hispanics of all races. Minority births included 21,868 black infants (23.2 percent), 5,739 Hispanic infants of all races (6.1 percent), and 4,277 Asian infants (4.5 percent) (Virginia Center for Health Statistics). Numbers of Hispanic and Asian births each rose over 25 percent from five years prior. Increasing births to these minority populations has occurred concurrently with an increase of immigrants to the state from these areas of origin. These changes implicate the need to monitor health status in specific minority groups.

The 1998 fertility rate equaled 60.7 live births per 1,000 females aged 15-44. Fertility rates remained higher among blacks (67.5) compared to whites (57.2). While 25-29 year olds had the highest age-specific rate, fertility rates rose among females in their thirties and forties. As the reproductive cohort in Virginia continues to age and women nearing the end of their reproductive years increase their fertility, attention to the special health needs and more tailored perinatal assessments for these women will become increasingly important. Conversely, fertility rates among those under 15 and 15-17 year olds fell to lows in 1998 of 0.9 and 26.3, respectively (Virginia Center for Health Statistics). Drops in fertility have been most pronounced among the youngest adolescents. These reductions have contributed to the overall health status improvement of the maternal and child health population as teen mothers and fathers are often ill-equipped economically and emotionally for parenthood and often experience poorer outcomes including higher rates of mortality.

Table 3: Resident Live Births by Selected Characteristics, Virginia 1994-98

	All	Nonmarital	Teen	White	Black	Asian	Hispanic (All

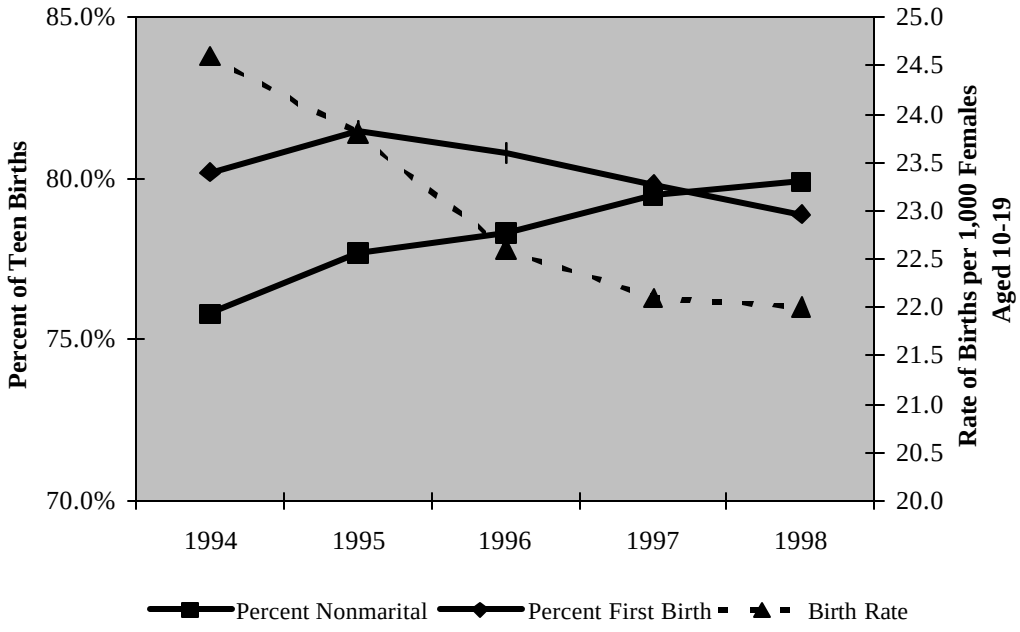
	Births			(aged 10-19)								Races)	
		Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
1994	94,355	27,583	29.2	10,666	11.3	68,678	72.8	22,103	23.4	3,195	3.0	4,562	4.8
1995	91,871	26,961	29.3	10,479	11.4	66,597	72.5	21,119	23.0	3,649	4.0	4,798	5.2
1996	92,115	26,592	28.9	10,109	11.0	66,559	72.3	20,749	22.5	3,922	4.3	5,088	5.5
1997	91,664	26,893	29.3	9,999	10.9	65,474	71.4	20,911	22.8	3,999	4.4	5,367	5.9
1998	94,114	28,057	29.8	10,102	10.7	66,872	71.1	21,868	23.2	4,277	4.5	5,739	6.1

Source Data: Virginia Center for Health Statistics

The proportion of all births to teens declined to 10.7 percent in 1998 although the number of teen births (n = 10,102) represented a slight annual increase. Both the number and proportion of births to teens under 18 continued falling among both whites and blacks. In 1998, 3,454 births (3.7 percent of all births) were to females under age 18. This was a drop of over 200 fewer births from the previous year. For whites, 2.5 percent of all births were to this age cohort. Births to teens under 18 were higher in blacks (7.8 percent) and Hispanics of all races (3.5 percent). The proportion among blacks, however, was a drop from 9.6 percent in 1995 (Virginia Center for Health Statistics).

One out of five teen births in 1998 was a second or higher order birth. White teens, who accounted for over half of all teen births, had a prior birth in 17.3 percent of cases. Among blacks, nearly one out of four (24.4 percent) giving birth in 1998 had a prior birth. The proportion of teens whose birth is a first birth has declined slightly in the past five years from 80.2 percent to 78.9 percent (Chart 1). This has been more obvious among white teens going from 84.0 percent in 1994 to 81.9 percent in 1998. The proportion of teens whose birth is the first one, however, has remained constant or slightly risen among the under 18 age cohorts for both whites (92.6 percent) and blacks (86.7 percent).

Chart 1: Teen Births by Selected Characteristics, Virginia 1994-98

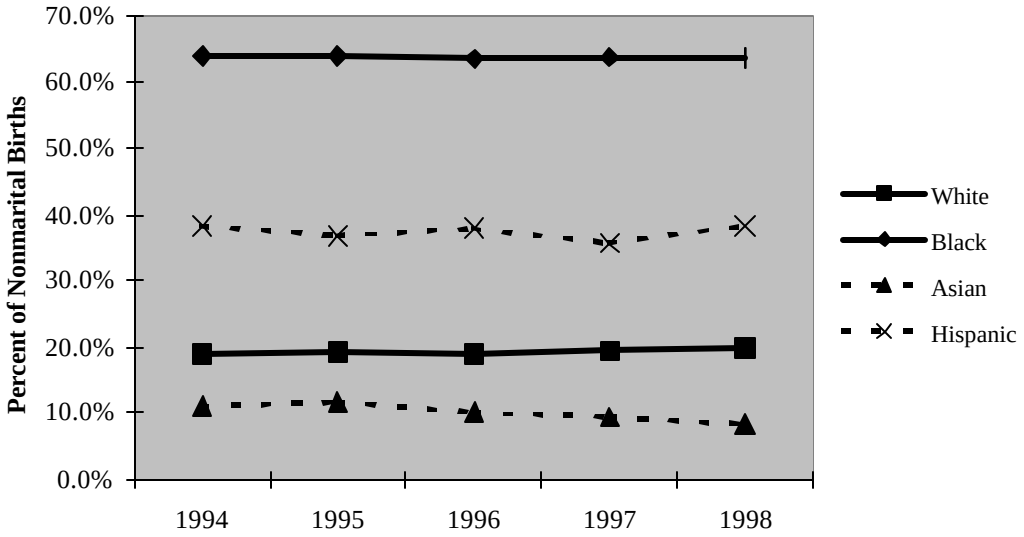


Source Data: Virginia Center for Health Statistics

These data, however, highlight needs to extend these efforts to older teens and young adults. Increases in percentages of nonmarital births, and repeat births among teens despite their overall declining birth rates further underscore the importance of preventing teenage pregnancies and the potential father-absent, fragile family structure into which many infants born to teens enter.

Continuing a trend begun decades earlier, nonmarital births rose to a high of 28,057 in 1998. Nearly thirty percent (29.8 percent) of births were to unmarried mothers. It is likely that many of these births are to father-absent families. The proportion among blacks (63.7 percent) was triple that observed among whites (19.9 percent). Whites, however, have shown the larger proportional increases in the past five years while blacks have shown slight declines. Hispanics of all races experienced 38.3 percent of births as nonmarital, while Asians had the lowest proportion at 8.3 percent (Chart 2). Reaching 79.9 percent in 1998, the proportion of teens having nonmarital births has continued to grow despite the decrease in the teen birth rate. Among 20-24 year olds, nearly half (48.5 percent) of births were nonmarital in 1998. Of all nonmarital births occurring in 1998, 71.0 percent were to females aged 20 and older (Virginia Center for Health Statistics).

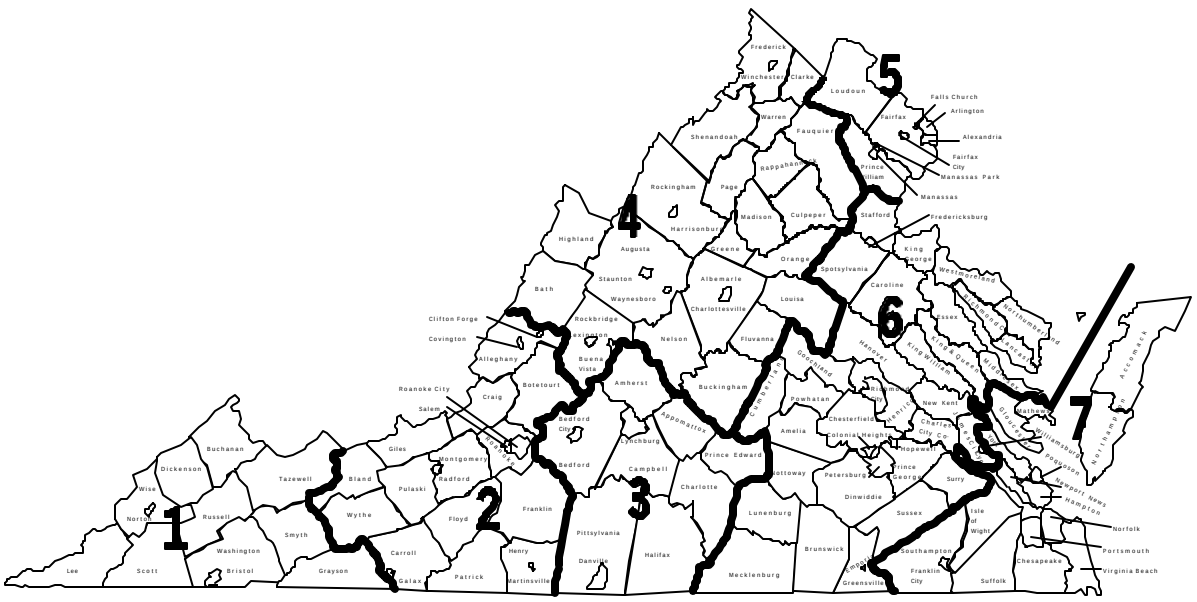
Chart 2: Resident Nonmarital Births by Race and Ethnicity, Virginia 1994-98



Source Data: Virginia Center for Health Statistics

According to *Perinatal Underserved Areas in Virginia, 1999*, births remained concentrated in the eastern half of the state in 1997. Over half of all births occurred to Northern and Eastern Virginia (Regions 5 and 7) residents (See Map 1 for Perinatal Regions). An additional 20.6 percent were to Central Virginia (Region 6) females. Fertility rates were highest in heavily populated areas with Eastern Virginia (Region 7) leading at 62.1 in 1997. Sparsely populated, Southwest Virginia (Region 1) had the lowest fertility rate at 50.4. While 30 percent or more births were to blacks in Regions 3, 6, and 7, less

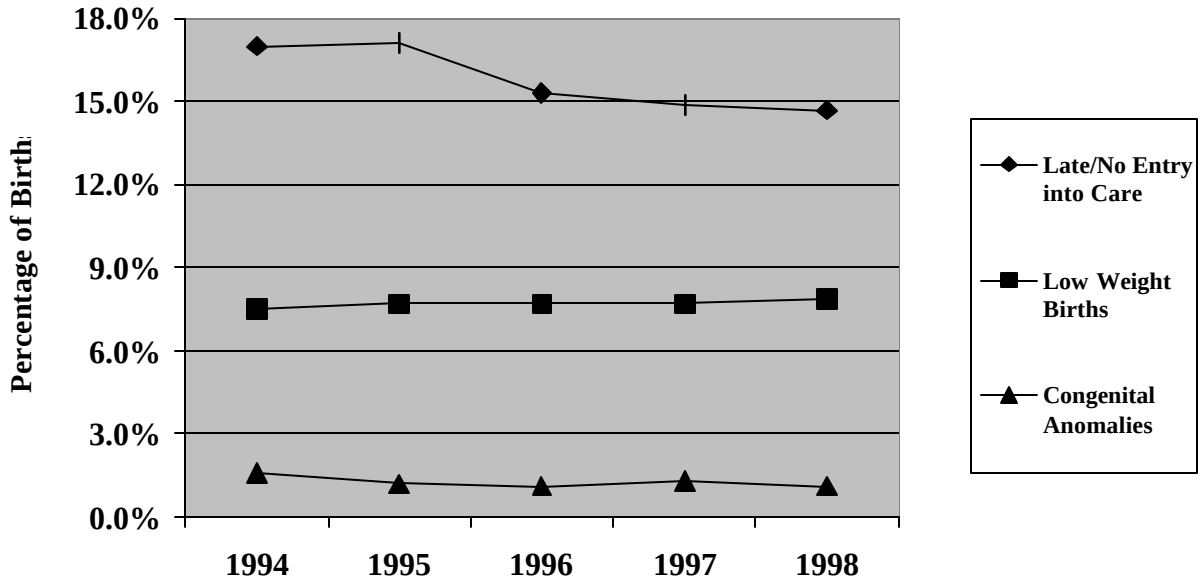
Map 1: Perinatal Regions:
Virginia, 1999



than 2 percent were to blacks in Region 1. Northern Virginia (Region 5) had the highest proportion of births to Asians (10 percent) and Hispanics (14.5 percent). Regions 1 and 3 experienced the highest percentages of teen births at ≥15.0 percent. One third or more of Regions 3, 6, and 7 births were nonmarital.

With increasing early entry into prenatal care, Virginia had 84.8 percent of pregnant women beginning care in the first trimester in 1998**.** Overall increases in early prenatal care utilization may reflect earlier identification of pregnancy and increased awareness regarding the importance of prenatal care**.** To date, however, Virginia has not met the Healthy People 2000 objective of 90 percent starting care in the first trimester. Women starting care in the second trimester dropped the most to 11.4 percent. An additional 2.2 percent of mothers started care in the last trimester and 1.1 percent received no care at all (Chart 3) (Virginia Center for Health Statistics).

Chart 3: Trends in Perinatal Indicators: Virginia, 1994-98



Note: Late/No Entry into Care = 2nd trimester, 3rd trimester, and no care
Source Data: Virginia Center for Health Statistics

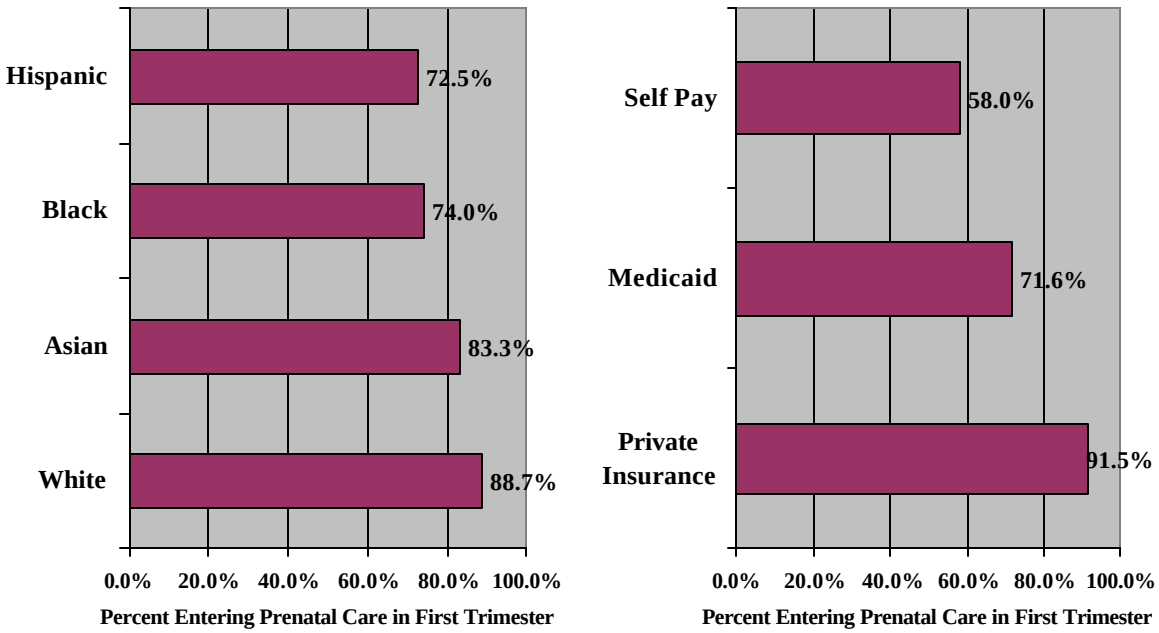
Race, age, marital status, payment source, and region highlighted differences in prenatal care utilization. Hispanics of all races had early care least frequently (72.5 percent) in 1998 (Chart 4, next page). Later prenatal care utilization by Hispanic women reflects racial and ethnic disparities which

may be magnified for immigrants (legal or illegal) who may fear contact with medical or government systems, encounter language barriers, or have a lack of resources and knowledge to obtain care.

Blacks also have continued to demonstrate lower rates of early care. The gap between whites and blacks in obtaining early care has not improved in the past five years. While 25.5 percent of Hispanics did not start care until the second or third trimester, 1.2 percent had no care, a figure close to the state average. Blacks, however, had 2.3 percent with no care. They disproportionately represented 46.9 percent or 498 out of the 1,062 women delivering without prior care in 1998 (Virginia Center for Health Statistics). These differences may be related to acceptability of care and lifestyle characteristics.

Of 219 teens under age 15 who gave birth in 1998, less than half (41.1 percent) started care in the first trimester. Those aged 15-17 entered care in the first 13 weeks of pregnancy 63.8 percent of the time. Among unmarried mothers, 70.7 percent obtained first trimester care in 1998. Only 71.6 percent of Medicaid patients entered care in the first trimester (Virginia Center for Health Statistics). Lower utilization may be related to delays in obtaining Medicaid approval as well as other factors such as acceptability of care and belief in the importance of early prenatal care.

Chart 4: First Trimester Prenatal Care Utilization by Race and Payment Source

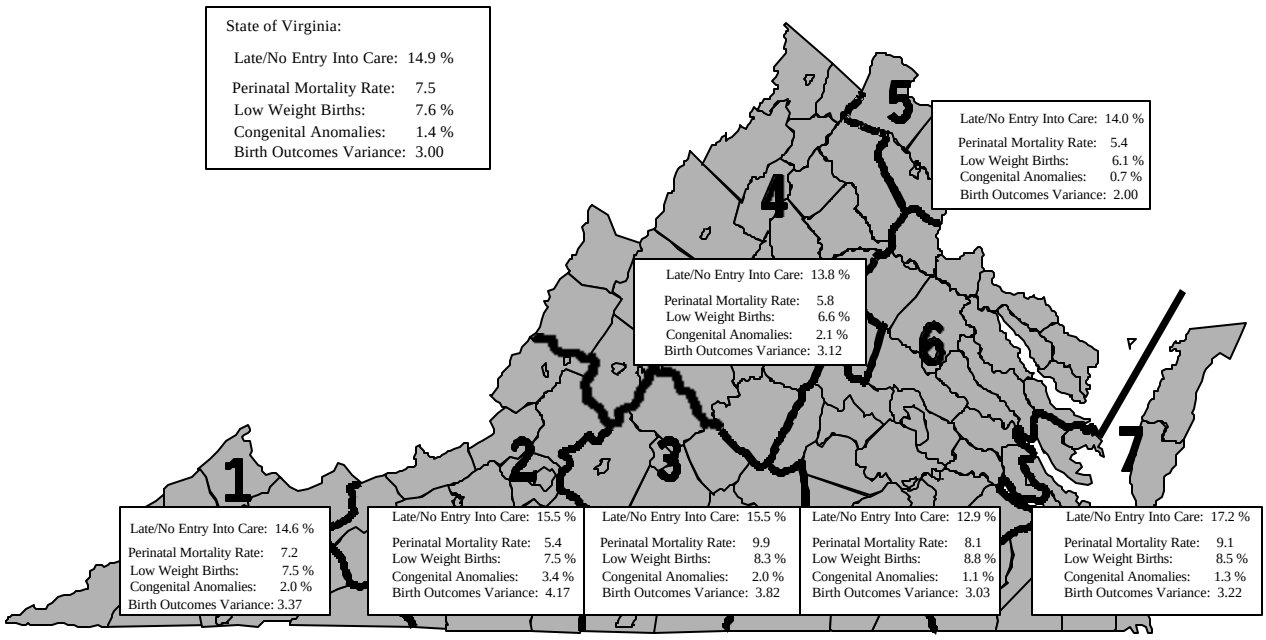


Based on the report *Perinatal Underserved Areas in Virginia, 1999* Central Virginia (Region 6) had the highest prenatal utilization in 1997 with 12.9 percent of women having late/no care (Map 2). Suburban communities boosted the region's figure, yet pockets such as Southside and Northern Neck had significantly higher underutilization. The lowest utilization was found in South Central (Region 3) and Eastern (Region 7) Virginia as each had 17 percent or higher late/no care figures. Norfolk and Portsmouth Cities greatly affected Eastern Virginia data. Communities with previously low care patterns, such as the Eastern Shore, Richmond City, and Southside Virginia, improved between 1993 to 1997, but remained worse than the state overall. Although facing difficult terrain, Regions 1 and 4 had low rates of late/no care entries. An area with a recent influx of Hispanic immigrants, Central Shenandoah in Region 4, however, experienced decreased utilization.

Other high-risk groups demonstrated lower rates of utilization. Only 38 percent of health department prenatal patients obtained first trimester care in FY 97. According to the Virginia Supplemental Nutrition Program for Women, Infants and Children (WIC) program, 11 percent of participants were pregnant in 1997 and 46 percent began prenatal care in the first trimester.

An analysis by the Virginia Center for Health Statistics on adequacy of prenatal care using the Kotelchuck index found that between 1983-1997, 72 percent of pregnant women received adequate

Map2: Underserved Underutilization Indicators by Perinatal Regions: Virginia, 1999



Notes: Source Data from Virginia Center for Health Statistics
Late/No Entry Into Care: 1997, Perinatal Mortality Rate, Low Birth Weights, and Congenital Anomalies: 1993-97 Perinatal

plus or adequate prenatal care, 14 percent received intermediate care, and 12 percent received inadequate care. According to 1998 data, 82.1 percent of pregnant women received adequate plus or adequate care**.** The proportion however was lower among Medicaid patients with 71.9 percent receiving adequate or adequate plus care. Increases in adequacy of care are related to both women starting care earlier and receiving the recommended number and timing of visits.

The proportion of low weight births increased in the past five years reaching a high of 7.9 percent in 1998. Very low weight births (under 1,500 grams) also inched up to 1.7 percent, another peak mark. Contributing to low weight births, multiple births rose to 2,964 (3.1 percent of all births) in 1998. Over half (56.5 percent) of multiples had low birth weights and plural births accounted for 22.4 percent of low weight births**.** Multiple births have significantly increased concurrently with the spread of assisted reproductive technology. The medical, social, and ethical implications of these advancing technologies present an area requiring further study and evaluation**.**

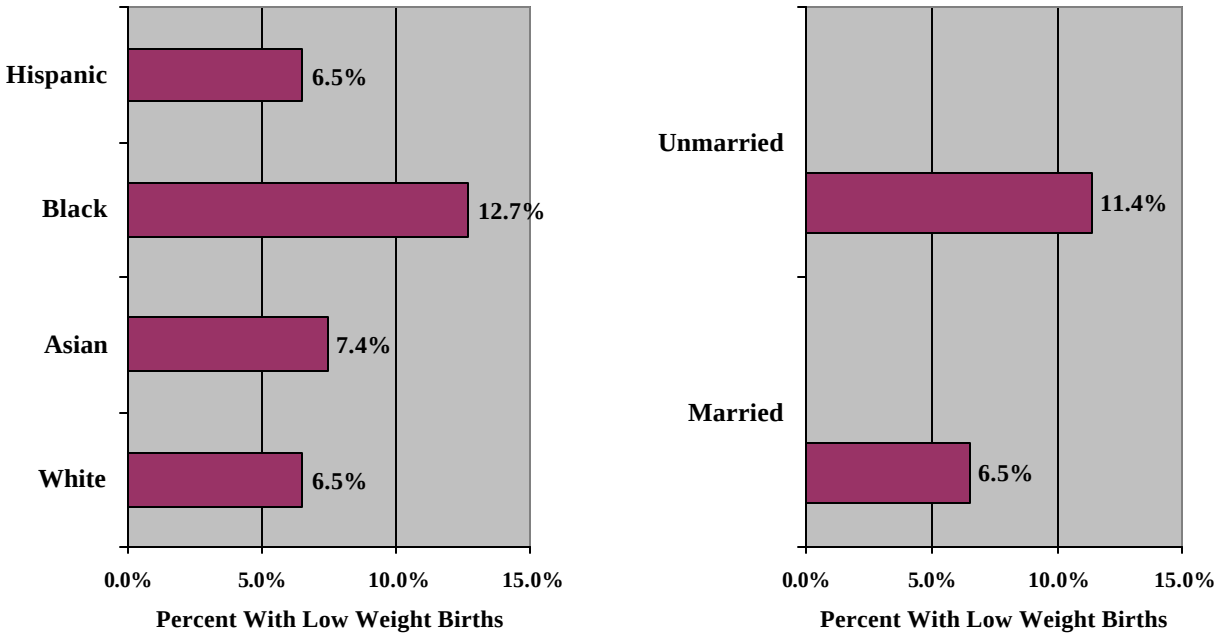
Among singleton births, low weight births have not increased as they were 6.5 percent in 1995 and 6.4 percent in 1998. Data for very low weight births among singletons, revealed an incidence of 1.3 percent in 1998 which has varied by a tenth of a percent over the past four years. Virginia will not likely meet the Healthy People 2000 objectives of no more than 5 percent low weight and 1 percent very low weight births.

Racial disparities persisted as blacks (12.7 percent) had low weights at nearly double that seen in Whites (6.5 percent) in 1998, although both groups experienced increases. While Hispanics had low entry into first trimester care, their low weight births (6.5 percent) remained the same as all whites (Chart 5). Asians had a higher percentage of low weight births (7.4 percent) than whites. All other minority groups, however, had lower proportions than blacks. Understanding the reasons behind these differences among minority groups themselves will enable efforts to reduce racial and ethnic disparities from whites. Differences may potentially be related to informal community health systems and practices, which vary by culture. The roles of poverty, education, degree of acculturation and level of alienation present areas of study to help explore these differences. As recent immigrant families produce second generations, health

status indicators will need to be closely studied to help differentiate factors from country of origin versus environmental ones.

Other growing high-risk groups, such as unmarried mothers have also contributed to the overall increase in low weight births. In 1998, 11.4 percent of infants born to unmarried mothers were low weight compared to 6.5 percent among infants born to married mothers. Teens and women in their forties demonstrated the highest percentages (> 10 percent) of age-specific low weight births. Births to mothers covered by Medicaid were also more likely to be low weight at 10.3 percent versus 7.1 percent among non-Medicaid infants.

Chart 5: Low Weight Births by Race and Marital Status, Virginia 1998



Source Data: Virginia Center for Health Statistics

Central Virginia (Region 6) had the highest proportion of low weight infants at 8.8 percent between 1993-97 despite having the highest prenatal care utilization *(Perinatal Underserved Areas in Virginia, 1999)*. South Central (Region 3) and Eastern (Region 7) Virginia also had greater than 8.0 percent low weight births. These three regions also had the highest proportions of births to black females, unmarried mothers, and teens. Northern Virginia (Region 5) had the lowest proportion of low weight births at 6.1

percent. Hispanics and Asians in this perinatal region had slightly higher proportions at 6.8 percent and 6.6 percent, respectively.

An evaluation of the Regional Perinatal Councils (RPCs) and regionalization progress found that mothers delivering infants with birth weights under 1,500 grams were most likely to receive care in perinatal centers. *(Assessment of Regional Perinatal Coordinating Councils, 1997)* A hospital record review confirmed that very low birth weight infants needing neonatal care have been born in appropriate facilities with 81 percent being born in specialty and subspecialty hospitals, this however is shy of the 90 percent Healthy People 2000 target.

In 1998, 1,011 or 1.1 percent infants born had congenital anomalies identified at birth. While racial disparities have been evident, the 1998 difference was the lowest ever at 1.0 percent among whites and 1.3 percent among blacks. The most commonly occurring anomalies were digit malformations or misnumbers, musculoskeletal/integumental anomalies, and cleft lip/palate (Virginia Center for Health Statistics).

According to *Perinatal Underserved Areas in Virginia, 1999*, congenital anomalies were highest in Blue Ridge (Region 2) at 3.4 percent of infants born between 1993-97. Elevated rates in Roanoke City of 14.5 percent (1993) and 15.1 percent (1994) contributed to this figure. Reporting artifacts were found by the Blue Ridge RPC and in the past two years less than 2 percent of Roanoke resident births had anomalies. Anomalies were present in greater proportions in the western areas (Regions 1-4) of the state which are the least populated and most mountainous areas. Each region except South Central (Region 3) has a predominantly white population. Northern Virginia (Region 5) had the lowest proportion of births with anomalies at 0.7 percent.

Perinatal mortality, defined in Virginia as natural fetal deaths occurring at 28 weeks or greater gestation and infant deaths occurring under seven days of age (hebdomadal), registered 666 deaths in 1998. The 1998 rate of 7.1 per 1,000 perinatal base (live births and natural fetal deaths 28 weeks and over) was 11.3 percent less than 8.0 in 1994. Despite decreases in both racial groups, the 1998 black perinatal mortality rate (12.8) remained double that seen in whites (5.6). Blacks experienced 42.0 percent of all

and 58.5 percent of teen 1998 perinatal deaths. Teens accounted for 10.2 percent of perinatal deaths, yet their rate (6.4) was not higher than seen in all females (Virginia Center for Health Statistics).

According to *Perinatal Underserved Areas in Virginia, 1999*, the lowest rate five-year (1993-97) perinatal mortality rate, 5.4, was observed in both Blue Ridge (Region 2) and Northern Virginia (Region 5). The worst rate, 9.9 in South Central (Region 3), was 83.3 percent greater. Eastern Virginia (Region 7) had the second highest perinatal mortality rate at 9.1. These areas had risk factors such as high proportions of minority populations and late/no entry into care.

Slightly increasing in the past five years, natural fetal deaths reached 7,524 in 1998 (Table 4, next page). The rate rose from 4.7 (1994) to 4.9 (1998) natural fetal deaths per 1,000 females aged 15-44. No further increases can transpire for Virginia to remain within the Healthy People 2000 target of 5.0. Blacks had a higher rate (5.9) compared to whites (4.6). The majority of fetal deaths (92.1 percent) occurred under 20 weeks. The leading causes of natural fetal deaths (under 20 weeks) were spontaneous abortion (57.2 percent), ectopic pregnancy (9.4 percent) and immaturity (1.4 percent). While females aged 25-29 had the highest age-specific natural fetal death rate (7.2), women in their forties had the highest proportion of pregnancies ending in a natural fetal death at 14.4 percent (Virginia Center for Health Statistics).

Table 4 : Resident Natural Fetal Deaths, Virginia 1994-98

	Natural Fetal Deaths	Rate per 1,000 females aged 15-44	28 Weeks and Over		20-27 Weeks		Under 20 Weeks	
			Number	Rate	Number	Rate	Number	Rate
1994	7,320	4.7	286	0.2	329	0.2	6,705	4.3
1995	7,496	4.9	261	0.2	386	0.2	6,849	4.4
1996	7,679	5.0	272	0.2	350	0.2	7,057	4.6
1997	7,532	4.9	246	0.2	329	0.2	6,957	4.5
1998	7,524	4.9	265	0.2	333	0.2	6,926	4.5

Source Data: Virginia Center for Health Statistics

Natural fetal deaths occurring at 28 weeks and beyond fell slightly to 265 with a constant rate of 0.2 per 1,000 females aged 15-44 over the past five years. The leading causes of death for this group were conditions of the umbilical cord (14.3 percent), congenital anomalies (7.2 percent) and placenta praevia and other placental separation (6.8 percent) (Virginia Center for Health Statistics).

The numbers and rates of induced terminations of pregnancy have slightly increased in the past four years but remain lower than 1994 figures. In 1998, there were 25,913 induced terminations, which equaled a rate of 16.7 per 1,000 females aged 15-44 (Table 5, next page). Rates were highest among blacks (31.3) versus whites (12.1). In 1998, 30.0 percent of all pregnancies to black females ended in an induced termination compared to 16.4 percent among whites. The number of induced terminations to blacks has increased while the opposite has occurred among whites. Increases in rates among blacks will require future monitoring. This potential trend could be a possible artifact from welfare reform. The state of New Jersey identified this occurrence which leveled off several years after initiation of their welfare reform. Teens accounted for 18.7 percent of all induced terminations and their number (n = 4,858) and rate (10.6) fell to all time lows in 1998. Females aged 20-24 had the highest proportion (31.5 percent) and highest age-specific rate (34.1) of induced terminations. The majority (83.6 percent) of induced terminations was nonmarital (Virginia Center for Health Statistics).

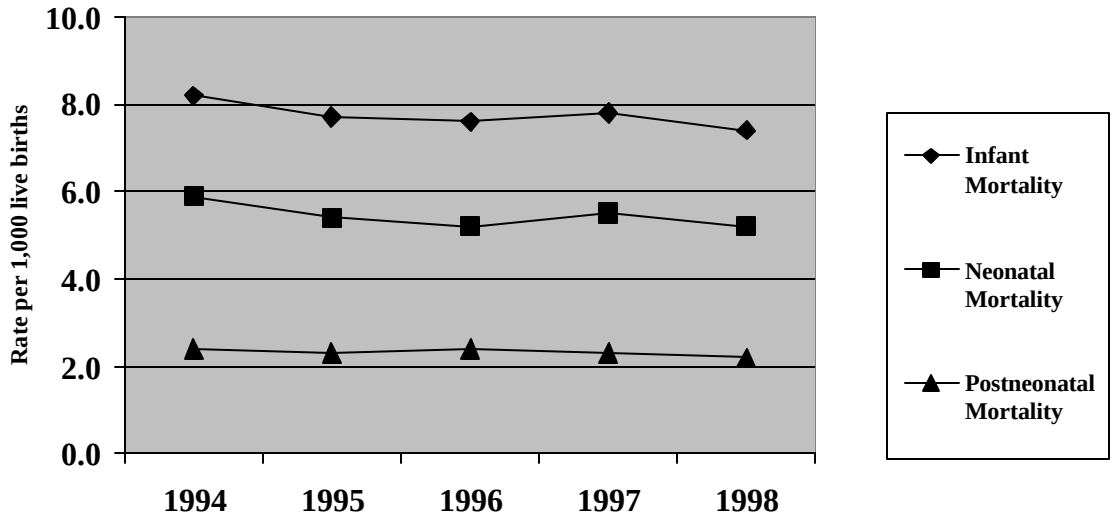
Table 5: Resident Induced Terminations of Pregnancy by Selected Characteristics, Virginia 1994-98

	Induced Terminations o Pregnancy	Rate per 1,000 females aged 15-44	Females aged 10-19		White		Black	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
1994	26,213	17.0	5,444	12.5	15,655	13.4	9,484	29.9
1995	25,548	16.5	5,212	11.8	15,077	12.9	9,188	28.6
1996	25,752	16.6	5,331	11.9	14,591	12.5	9,646	30.0
1997	25,875	16.7	5,125	11.3	14,189	12.1	10,176	31.5
1998	25,913	16.7	4,858	10.6	14,132	12.1	10,175	31.4

Source Data: Virginia Center for Health Statistics

Progress continues to be made in reducing infant mortality with these deaths falling to 695 in 1998. Between 1994 and 1998, infant mortality rates dropped from 8.2 to 7.4 deaths to infants under one year per 1,000 live births (Chart 6). While Virginia has not yet made the Healthy People 2000 goal of 7.0, it may be possible to achieve if these declines continue over the next two years.

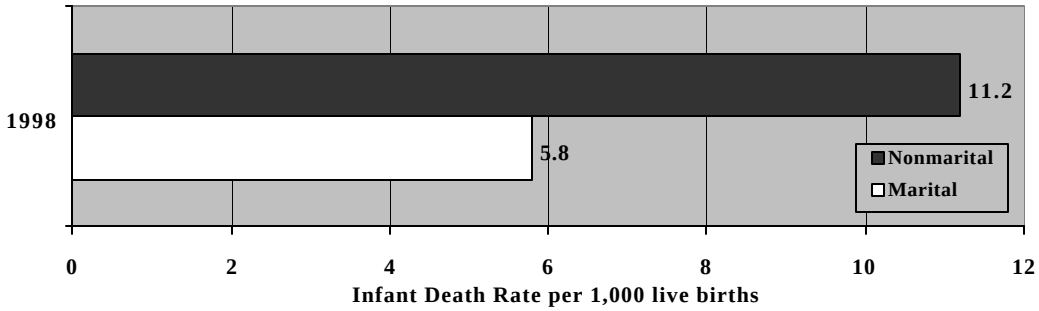
Chart 6: Infant, Neonatal, and Postneonatal Mortality, Virginia 1994-98



Source Data: Virginia Center for Health Statistics

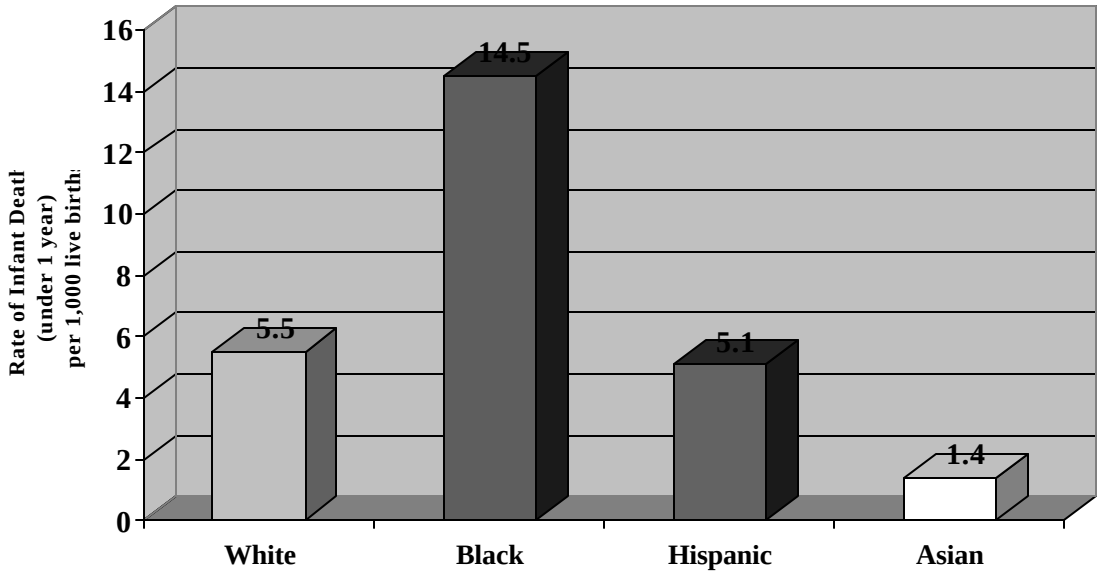
Severe racial disparities remained evident among blacks having an infant mortality rate (14.5) which was 2.6 times higher than that of whites (5.5) in 1998. While the ratio has fluctuated, the 1998 ratio was the second highest since 1990. Hispanics experienced fluctuations in their infant mortality rate, which in 1998 fell back to 5.1 after four years of increases. The number of Hispanic infant deaths was 29 in 1998. Asians had the lowest 1998 rate at 1.4 (Chart 7). Teens had a higher overall rate (11.6) and also reflected racial disparities. Females aged 30-34 had the lowest age-specific infant death rate (6.2). Unmarried mothers represented a disproportionately higher (45.2 percent) amount of infant deaths. Many of these infants may be in father-absent families. Their infant mortality rate (11.2) was nearly double that observed among infants born to married mothers (5.8) (Chart 8). Infants under Medicaid coverage had a 1998 death rate of 9.1 versus 6.7 among non-Medicaid infants (Virginia Center for Health Statistics).

Chart 7: Resident Infant Mortality Rates by Marital Status, Virginia 1998



Source Data: Virginia Center for Health Statistics

Chart 8: Resident Infant Mortality by Race/Ethnicity, Virginia 1998



Source Data: Virginia Center for Health Statistics

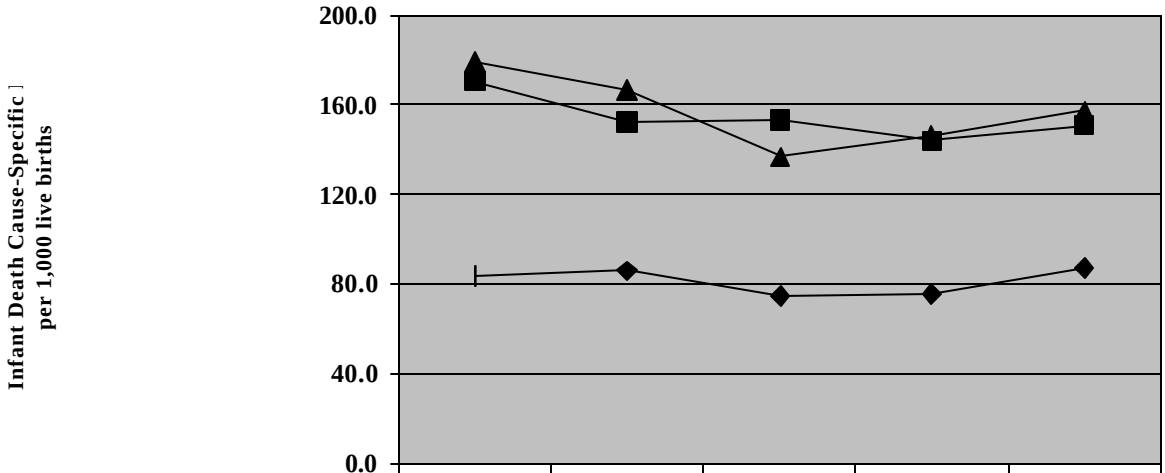
Hebdomadal deaths (infant deaths under seven days) decreased from 469 in 1994 to 401 in 1998 with corresponding rate drops of 5.0 to 4.3 per 1,000 live births. Eight out of ten infants (85.8 percent) dying in the first week had low weights. Women with infants experiencing a hebdomadal death had lower prenatal care utilization as 75.3 percent had started care in the first trimester and 9.2 percent received no care at all. These figures worsened among blacks where a hebdomadal death occurred to 64.6 percent (first trimester care) and 16.7 percent (no care) (Virginia Center for Health Statistics).

Nearly three-quarters (73.4 percent) of infant deaths occurred under 28 days following birth in 1998. Neonatal death rates have continued declining in the past five years from 5.9 in 1994 down to 5.2 per 1,000 live births in 1998. This was still short of the Healthy People 2000 objective (4.5). Among blacks, this rate had dipped but rose again in the past two years to 10.8, which remains nearly triple the rate among whites (3.7) where drops have been more pronounced. Nearly half (48.2 percent) of the 489 neonatal deaths in 1998 were to black females (Virginia Center for Health Statistics).

Postneonatal death rates fell to their lowest level at 2.2 deaths per 1,000 live births in 1998, which met the Healthy People 2000 target of 2.5. Black females accounted for 81 or 39.3 percent out of the 206 postneonatal deaths. The 1998 death rate among blacks (3.7) was double that seen among whites (1.8) (Virginia Center for Health Statistics).

The leading cause of infant death in 1998 was disorders related to short gestation and low birth weight (n = 148), which exceeded deaths from congenital anomalies (n = 142) by six cases. Over one-third (35.1 percent) of low weight infants who died weighed less than 500 grams and another 28.0 percent weighed between 500-749 grams. All deaths from this top cause occurred in the neonatal phase and represented 30.3 percent of all neonatal deaths. The number and rate of infant deaths from disorders related to short gestation and low birth weight fell to a low in 1996, but have slightly risen again in the past two years yet remain at a level lower than 1994 (Chart 9, next page). This pattern was most pronounced among white, but not black infants (Virginia Center for Health Statistics).

Chart 9: Resident Infant Death Cause-Specific Rates, Virginia 1994-98



	1994	1995	1996	1997	1998
SIDS	83.7	86.0	74.9	75.3	87.1
Congenital Anomalies	170.6	152.4	153.1	144.0	150.9
Low Birth Weight & Short Gestation	179.1	166.5	136.8	146.2	157.3

Source Data: Virginia Center for Health Statistics

Congenital anomalies were the second leading cause of death for both neonates and postneonates in 1998. Heart malformations followed by respiratory system anomalies were the most frequently cited in these deaths. The rate and number of infant deaths from congenital anomalies fell between 1994 and 1995 and has remained steady in the past four years. The number of deaths declined among white infants.

Sudden Infant Death Syndrome (SIDS) was the third leading cause of all infant deaths and the top cause of all postneonatal infant deaths. In 1998, 82 infants died of SIDS, which were 11.8 percent of infant deaths. The majority (91.5 percent) of SIDS deaths occurred after 28 days of age. Rates have fluctuated and the 1998 SIDS rate rose after two prior years of lower rates. Among black infants, the number of deaths from SIDS fluctuated, but reached a five-year high of 39 in 1998. Among whites, the numbers steadily dropped between 1994-98. Data from the Virginia SIDS Program found co-sleeping or other

sleep hazards present in 20 out of 56 (35.7 percent) 1998 SIDS cases reviewed. Over half (53.5 percent) of all infant deaths were from one of the three leading causes.

According to *Perinatal Underserved Areas in Virginia, 1999*, five-year infant death rates (1993-97) revealed the highest occurrences in Regions 7 (11.1) and 3 (10.6). Regions 2, 4, and 5 should meet the Healthy People 2000 goal of no more than 7.0 deaths per 1,000 births based on 1993-97 figures. Leading cause of death (1995-97) varied by region as in Regions 1, 2, 4, and 5, congenital anomalies comprised the top cause of infant death. In Regions 6 and 7, disorders related to short gestation and low birth weight ranked as the leading cause of infant deaths. Eastern Virginia (Region 7) residents accounted for 45.3 percent of all state deaths from this cause. In South Central (Region 3) Virginia, SIDS caused the most deaths. South Central (Region 3) and Southwest (Region 1) had SIDS rates, which were nearly 50 percent greater than the entire state.

These variations match some demographical characteristics. Regions 6 and 7 each have significant minority populations, particularly black cohorts residing in large urban areas such as Richmond and Norfolk. Regions 1,2, and 4 are predominantly white and this racial group has historically experienced deaths most frequently from congenital anomalies. In Regions 1 and 3 where SIDS rates remain elevated, high levels of poverty persist although occurring to differing racial groups. Rates of smoking in areas such as Appalachia (Region 1) and Southside (Region 3) may be potential contributors. Recognizing these differences enables RPCs to concentrate on the issues affecting their regions most prominently.

Between 1994-98, there were 20 maternal deaths. Of these 5 were from complications mainly related to pregnancy, 5 were from complications mainly in the course of labor and delivery, 8 were from complications of the puerperium, and 2 were pregnancies with abortive outcomes (ectopic pregnancies). Eleven deaths were to white mothers, 7 were to black mothers, and 2 were to mothers of other races (Virginia Center for Health Statistics). The 1998 maternal mortality rate, 3.2 deaths per 100,000 live births, met the Healthy People 2000 objective.

Promoting healthy behaviors and reducing risky behaviors among women remain health concerns. Preconceptional health, has become an increased Virginia Department of Health (VDH) service focus working toward the Healthy People 2000 objective of at least 60 percent of primary care providers who provide age-appropriate preconception care and counseling. The 1999 Virginia Behavioral Risk Factor Surveillance System (BRFSS) found that less than half (47 percent) of female respondents aged 18-44 were currently taking a multivitamin or vitamin with folic acid. Less than one-third (32 percent) of females aged 18-24 identified prevention of birth defects as a reason health experts recommend women taking folic acid. These proportions were higher among 25-34 year olds (48 percent) and 35-44 year olds (38 percent).

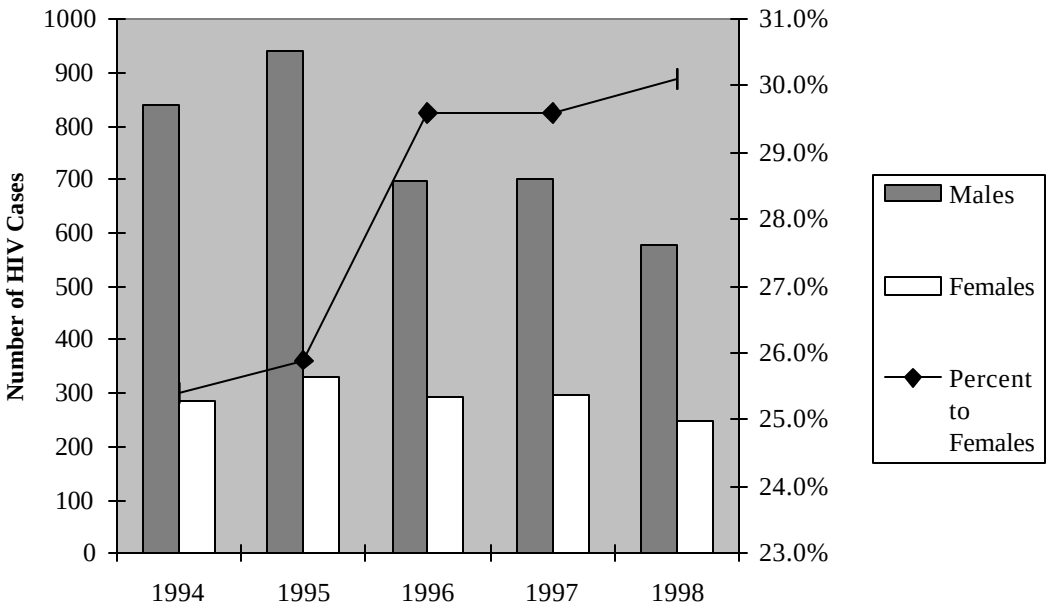
The number of neural tube defects identified among resident Virginia infants dropped by over half from 69 in 1997 to 32 in 1998. Efforts have continued to assure quality among hospital reporting and matching cases with birth certificate data. These issues, however, may have some impact on these data. An estimated 70 percent of neural tube defects may be prevented with folic acid supplementation of 400 mg daily. Recent statewide folic acid campaigns may also be contributing to the apparent reduction. As more data becomes available, Virginia will have a clearer picture of the trend for these defects.

While newly diagnosed Human Immunodeficiency Virus (HIV) cases among females dropped to 248, the proportion of all new HIV cases among females continued rising to 30.0 percent in 1998 (Chart 10, next page). Three-quarters of female HIV cases were among those aged 20-44. Black females represented 79.0 percent of these cases. Among males, the number of HIV cases fell to 577 in 1998 and 64.3 percent of these cases were to black males. The highest overall incidence was found in the Central Region. The percentage of HIV-positive mothers receiving AZT treatment before or during pregnancy or during delivery rose from 66 percent (31/47) in 1994 to 91 percent (41/45) in 1998. There were 10 newly diagnosed cases of pediatric HIV transmission in 1998 (Division of HIV/STD, Virginia Department of Health).

The number of AIDS cases among females in 1998 was 219, which was higher than the 175 observed five years prior, although the annual numbers have fluctuated. Among males, the numbers fell to 744. In

1998, racial disparities in AIDS cases peaked as 82.6 percent of females and 61.2 percent of males with this disease were black. The largest proportion (27.4 percent) of females with AIDS was aged 35-39. Less than 1 percent of all persons with AIDS were under the age of 20. In 1998, 66 females died from HIV infection and AIDS and they were disproportionately black (87.9 percent) (Virginia Center for Health Statistics).

Chart 10: New Cases of HIV by Gender, Virginia 1994-98



Source Data: Division of HIV/STD, Virginia Department of Health

With 13,370 total cases, chlamydia was responsible for over half of the reportable sexually transmitted diseases in 1998 (Division of HIV/STD, Virginia Department of Health). Because of Virginia's public health screening criteria, 85 percent of chlamydia reports are for females. The 1998 rate of 4.3 per 1,000 females aged 20-44 was the highest in the past four years. Half of chlamydia-infected females were aged 20-44. The chlamydia rate for all blacks is over 10 times greater than the rate for all whites.

In 1998, there were 4,523 cases of gonorrhea among females and over half (53.5 percent) of those infected were aged 20-44. Blacks were disproportionately represented with 77.9 percent of cases. Female, as well as male, rates for both gonorrhea and syphilis have declined in the past five years. The 179 total cases of syphilis to females in 1998 represented a drop of 40.7 percent from 1997. Congenital

syphilis cases consequently fell from 18 in 1994 to 5 in 1998 (Division of HIV/STD, Virginia Department of Health). This met the Healthy People 2000 objective of no more than 50 per 100,000 live births. While 16 infants died from congenital syphilis in the past four years, none occurred in 1998 (Virginia Center for Health Statistics).

In 1998, 1,675 rapes were reported to police, equaling one forcible rape every 5 hours and these are underreported (Virginia State Police). In 1997, 4,348 sexual assault victims sought services from Virginia sexual assault crisis centers and 34,668 abused women requested services from Virginia's spouse abuse programs. The Family Violence and Sexual Assault Hotline of Virginia received 234,759 calls. Virginia shelters provided 104,842 nights of shelter to 6,257 abused women.

Domestic violence during pregnancy affects up to 20 percent of women depending on the population surveyed and instruments used. Of VDH maternity patients surveyed in 1997, an average of 18.4 percent reported a history of physical abuse. Less than half of women have obtained community services for abuse, including the police. For women obtaining services, coordination among community agencies is often inadequate or nonexistent. For FY 99, 4,059 women were sheltered by programs funded by Department of Social Services (DSS) in Virginia, and 4,706 were turned away for lack of space.

Depression marks another area affecting women' health. Existing state databases, however, do not adequately capture outpatient diagnoses and treatment information. Treatment for mental disorders for girls aged 10-19 is second only to childbirth and pregnancy for hospitalizations. Mental health treatment in girls is particularly relevant since unaddressed problems may continue through a woman's life. In 1998, 182 female suicides occurred. This number increased from 143 in 1994. Among white females aged 20-44, 11.3 percent of deaths were suicides in 1998 (Virginia Center for Health Statistics).

Substance abuse among women, particularly pregnant women, is difficult to adequately assess and report due to scant accurate statewide data. According to 1998 self-reported birth certificate data, 9,706 infants (10.3 percent) were born to mothers admitting tobacco use. In addition, 651 infants were born to mothers admitting alcohol use, while 591 infants were born to mothers admitting drug use. Two cases of

fetal alcohol syndrome were identified at birth in 1998. Alcohol-induced deaths numbered 70 and drug-induced deaths reached 117 among females in 1998. Of these deaths, roughly two-thirds were coded to non-accidental causes. Nearly half of the drug-induced deaths were suicides (Virginia Center for Health Statistics).

A 1999 legislative study (*Report on Newborn Infants Dependent on Controlled Substance, 2000)* noted that Virginia law requires testing of infants and mothers if substance abuse is indicated in the baby. Local departments of social services (DSS) received 203 reports of substance-exposed infants from July 1998-March 1999. This study also noted that because substance abuse or dependency often goes undetected or unacknowledged, prevalence estimates of abuse and/or addiction may be substantially understated. Testing may not be conducted in all needed populations, in part, because resources are not available to assist with identified problems. Resource Mothers and other community workers report the inability to assist all women requesting substance abuse services because of the time and intensive labor required and mothers are often fearful of the consequences of testing.

Smoking is a lifestyle habit of major concern. With 21 percent of females aged 18 and older smoking according to 1999 BRFSS data, Virginia continues to exceed the Healthy People 2000 objective of 15 percent. Most women start smoking as teens. Reported smoking among 18-24 year old females was highest at 25 percent followed by 23 percent among 25-34 year olds and 23 percent among 35-44 year olds. The highest rates of smoking were identified among all respondents, including males, with incomes under $15,000 (31 percent), without employment (34 percent), and with less than a high school education (31 percent).

Smoking impacts women's and family health with cardiovascular disease and respiratory diseases, including lung cancer. Lung cancer, the primary cause of female cancer deaths, has been increasing among women over 45. The impact broadens in pregnant women who have higher complication rates and more frequently give birth to low weight infants. Among 1998 admitted pregnant tobacco users, 12.5 percent of their infants had low weights. Secondhand smoke may also be a factor in SIDS deaths.

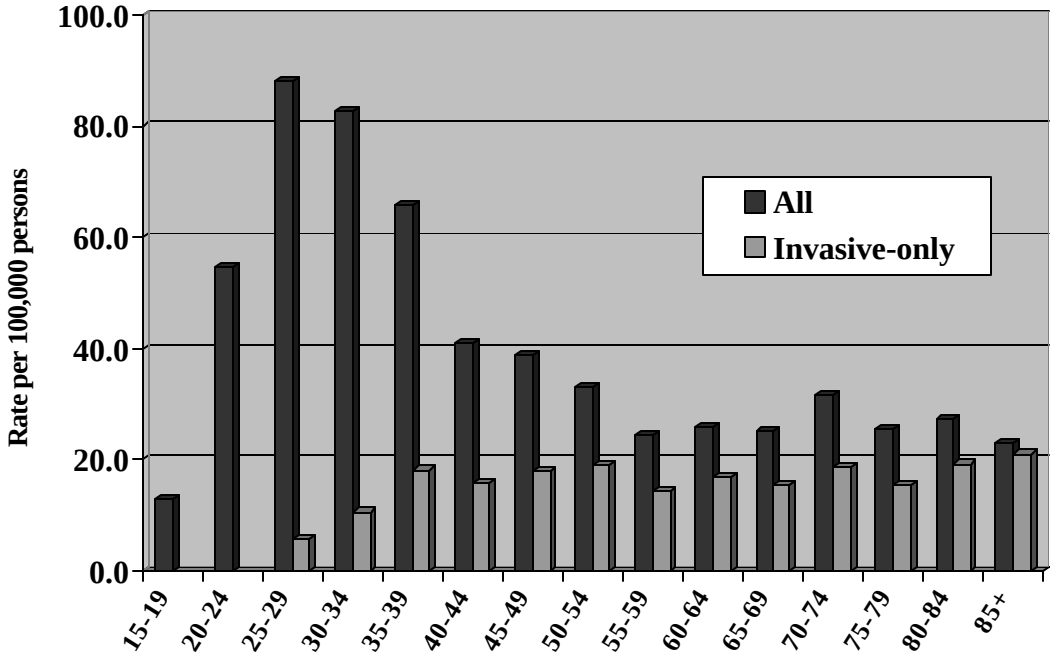
Chronic diseases not only contribute to the death of women, but they diminish the quality of their lives, which also impacts their families. An estimated 187,573 Virginia females (7 percent) have or have had diabetes, including those having gestational diabetes, although most of these do occur to women in their later years according to 1999 BRFSS data. Nearly one-quarter of all Virginia adult females (25 percent) have been diagnosed with hypertension. In 1996, an estimated 178,645 Virginia women over 50 had osteoporosis and an additional 348,345 women had low bone mass according to the National Osteoporosis Foundation.

Poor nutrition and sedentary lifestyles, often begun in the reproductive years, contribute to these conditions. According to 1999 BRFSS data, 65 percent of women surveyed reported eating fewer than 5 servings of fruits and vegetables a day. Lack of regular and sustained exercise and being overweight placed respectively, 74 percent and 33 percent, of women respondents at risk for health problems.

Another chronic disease concern, 1,627 cases of invasive cancers were diagnosed among females aged 15-44 in 1996 according to the Virginia Cancer Registry. Breast cancer was the most commonly diagnosed invasive cancer with 611 cases (37.6 percent). Cervical cancer (invasive) was the second most common, however, when including in-situ cases, the number of diagnoses in 1996 reached 925. Increases among those aged 10-19 raise public health concerns about the age of first sexual intercourse as cervical cancer has been linked to early sexual intercourse, multiple sexual partners and sexually transmitted diseases. Females aged 25-29 had the highest age-specific rate, 88.1 per 100,000 females, of all cervical cancers (including in-situ cases) (Chart 11, next page). Breast and cervical cancer rates fluctuated between 1992-96. In 1996, the age-adjusted (1970 U.S. population) rates per 100,000 females were 53.7 (all cervical), 30.1 (breast), and 7.3 (invasive cervical).

The other most frequent invasive cancers among females aged 15-44 were skin melanoma (n = 149), thyroid (n = 108), and ovary (n = 83). Skin melanoma rates per 100,000 females rose from 4.8 in 1992 to 7.8 in 1996 (age adjusted to U.S. 1970 population).

Chart 11: Age-Specific Cervical Cancer Rates, Virginia 1996



Source Data: Virginia Center for Health Statistics

The 1999 BRFSS found 66 percent of women aged 50 years older reported having a mammogram and a breast exam in the past two years. In addition, 85 percent of females aged 18 and older reported having a pap smear in the past three years. Women with incomes under $15,000 or with less than a high school education were most likely to never have had a mammogram (32 percent and 34 percent, respectively). The most recent utilization rates for mammography and clinical breast exam and pap smear testing met their related Healthy People 2000 objectives.

Racial disparities persist in cancer data. Black females were more likely to be diagnosed at later stages (regional or distant) for breast cancer with 35.9 percent compared to whites at 27.8 percent in 1996. Black females had higher rates of invasive morbidity and mortality from cervical cancer although most cancers of this site (73.4 percent) occur to whites (Virginia Cancer Registry). Hispanic and black females aged 50 and older had lower rates of obtaining mammography and breast exams within the past two years, according to the 1998 Virginia BRFFS, at 61.5 percent and 64.4 percent, respectively, than did white females (66.9 percent).

Primary causes of death among women have remained in the same in the past five years. For women in the youngest age groups 15-24 and 25-34, unintentional injuries were the 1998 leading cause of death at 15.9 and 14.6 deaths per 100,000 females, respectively (Table 11, next page). With middle aged women, malignant neoplasms moved to the top cause for those aged 35-44 (46.3), aged 45-54 (132.2), and aged 55-64 (321.7). Among those aged 65 and older, diseases of the heart caused the most deaths (Virginia Center for Health Statistics).

In 1998, the primary causes of death among women aged 15-44 due to intentional injury were suicides followed by homicides. The leading causes of death for unintentional injuries were motor vehicles (64.1 percent), poisonings (15.2 percent), fires (4.6 percent), and medical care related deaths (3.4 percent) (Virginia Center for Health Statistics). In addition to the deaths, there were more than 3,500 unintentional injury hospitalizations according to 1997 data. The leading causes for these were motor vehicles (35 percent), falls (27 percent) and poisonings (12 percent) (Center for Injury and Violence Prevention).

Among causes of death, racial disparities remain a serious concern. The 1998 death rate from malignant neoplasms was higher in black than white females of childbearing age with the largest disparity among 35-44 year olds. The HIV/AIDS death rate among black females aged 35-44 was 20 times higher than that seen in white females**.** Deaths from HIV/AIDS represented 8.7 percent of all deaths to black females aged 15-44. The death rate from homicide and legal intervention was 5 times higher among blacks aged 25-34 than whites. These accounted for 7.8 percent of deaths among black females of reproductive age. In deaths from heart disease, the rate among black females (18.0) was nearly triple that among whites (6.6). Rates of death from cerebrovascular diseases, diabetes, and chronic obstructive pulmonary disease were all higher in blacks than in whites of reproductive age. White females, however, exhibited higher rates of suicide (Virginia Center for Health Statistics).

Table 6: Leading Causes of Death to Females Aged 15-44, Virginia 1998

Leading Causes of Death by Age Group	Total	White	Black

	Number	Rate	Number	Rate	Number	Rate
Aged 15-24 Years						
Unintentional Injury	74	15.9	63	18.4	6	5.6
Suicide	19	4.1	15	4.4	2	1.9
Malignant Neoplasms	12	2.6	8	2.3	4	3.7
Diseases of the Heart	11	2.4	7	2.0	4	3.7
Homicide/Legal Intervention	9	1.9	4	1.2	5	4.7
Aged 25-34 Years						
Unintentional Injury	76	14.6	61	15.7	13	11.7
Malignant Neoplasms	55	10.6	37	9.5	15	13.5
Diseases of the Heart	37	7.1	21	5.4	15	13.5
Homicide/Legal Intervention	32	6.2	13	3.3	19	17.0
Suicide	27	5.2	24	6.2	2	1.8
Aged 35-44 Years						
Malignant Neoplasms	262	46.3	169	38.5	83	78.3
Diseases of the Heart	104	18.4	60	13.7	43	40.5
Unintentional Injury	87	15.4	59	13.5	28	26.4
Suicide	55	9.7	52	11.9	3	2.8
Homicide/Legal Intervention	28	4.9	16	3.6	11	10.4

Source Data: Virginia Center for Health Statistics

Overview: Young Children

The health of Virginia's young children continues to improve as measured by declining rates of death and reported infectious diseases. Population-based changes in other areas of health and development are more difficult to measure. While parenting practices in early childhood are recognized to be important for future health and development, assessment data are limited. In a 1999 statewide survey, 94 percent of Virginia children younger than 6 years were judged by their parent to be in excellent or good health. Parents identified 12 percent of young children as having special health care needs. Sixty-eight percent (68 %) of young children live with married parent(s), 22 percent with a single parent, and 9 percent with a parent who is separated or divorced (Virginia Children's Health Access Survey, 1999).

There were 104 deaths of children aged 1-4 in 1998. Unintentional injury (including poisoning) was the primary cause of death in this age group, accounting for 33.7 percent of the deaths (Table 7). This was followed by deaths due to congenital anomalies (9.6 percent), malignant neoplasms (8.7 percent), and diseases of the heart (8.7 percent) (Virginia Center for Health Statistics). Declining nearly 20 percent in

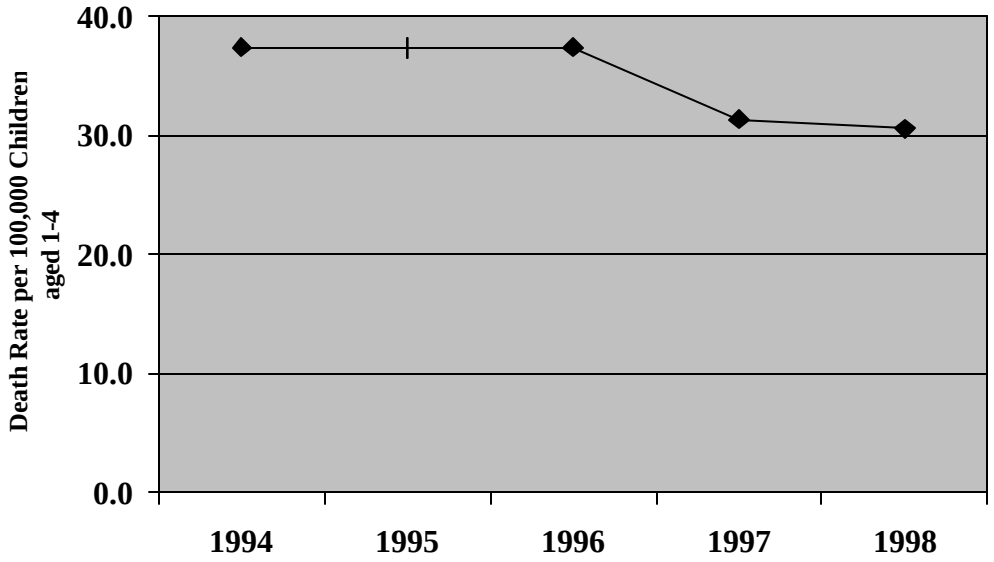
the past five years, the death rate for young children in 1998 was 30.5 per 100,000 (Chart 12). Fewer deaths from unintentional injuries, especially home injuries, are a major contributor.

Table 7: Leading Causes of Death for Young Children Aged 1-4, Virginia 1998

Leading Causes of Death by Age Group	Total		White		Black	
	Number	Rate	Number	Rate	Number	Rate
Aged 1-4 Years						
Unintentional Injury	35	10.3	23	9.6	10	11.0
Congenital Anomalies	10	2.9	7	2.9	3	3.3
Diseases of the Heart	9	2.6	7	2.9	2	2.2
Malignant Neoplasms	9	2.6	6	2.5	2	2.2
Homicide/Legal Intervention	8	2.3	3	1.2	5	5.5

Source Data: Virginia Center for Health Statistics

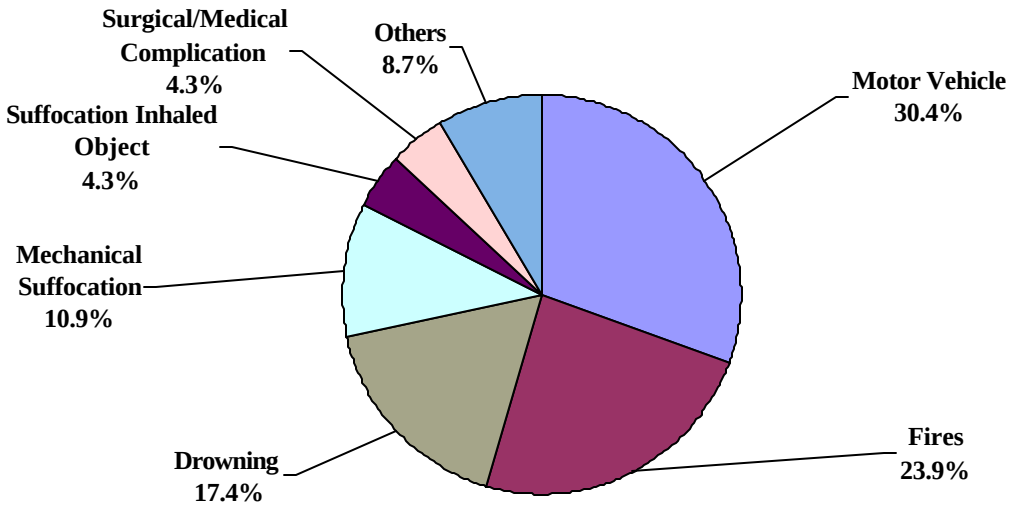
Chart 12: Rates of Death for Young Children Aged 1-4, Virginia 1994-98



Source Data: Virginia Center for Health Statistics

Despite a decline over the past 5 years, unintentional injury and poisoning remains the leading cause of death among young children aged 1-4 in Virginia. Motor vehicles, fire/flame, and drowning/submersion accounted for three-fourths of these deaths from 1994-98 (Chart 13). In 1998, nearly half (42.3 percent) of the injuries resulting in death occurred in the home (Virginia Center for Health Statistics). Poisoning and falls accounted for over half of the hospitalizations for unintentional injuries in this age group (Center for Injury and Violence Prevention).

Chart 13: Leading Causes of Death from Unintentional Injury for Young Children Aged 1-4, Virginia 1998



Source Data: Virginia Center for Health Statistics

In 1998, 14 children aged 1-4 died and 76 were hospitalized (1997) as a result of a motor vehicle injury. Fire/burn injuries caused 7 deaths in 1998 and 47 hospitalizations in 1997 among children aged 1-4. Virginia has met the Healthy People 2000 objectives for both motor vehicle deaths and residential fire deaths among young children.

Respiratory diseases are the leading cause of hospitalization among young children aged 1-4 in Virginia, accounting for 37 percent of all 1996 hospital discharges. The second most frequent cause was volume depletion. Infectious and parasitic diseases comprised the third most frequent reason for hospitalization of young children (Center for Injury and Violence Prevention).

As the leading cause of hospitalization among Virginia children aged 1-4, most 1996 respiratory disease hospitalizations were for pneumonia (42 percent), asthma (36 percent), and acute respiratory infection and influenza (16 percent). The 1997 asthma hospitalization rate for young children was 497 hospitalizations per 100,000 children aged 0-4. Males are more likely than females, and black children

are more likely than white children, to be hospitalized for pneumonia, asthma, and other respiratory diseases (Center for Injury and Violence Prevention).

Environmental tobacco smoke has been associated with increased rates of ear infections, asthma and respiratory problems in children. A 1996 survey estimated that 30 percent of young children are exposed to tobacco smoke at home which exceeds the Healthy People 2000 objective of 20 percent (Virginia BRFFS, 1996).

Infectious and parasitic diseases are the third leading cause of hospitalization among young children. In 1998, salmonellosis, giardiasis, campylobacteriosis, and shigellosis were the most commonly reported diseases among young children (Table 8) (Office of Epidemiology, Virginia Department of Health). Most of these commonly reported infectious diseases declined in the past five to ten years with the exception of giardiasis (Table 9, next page). The persistence of giardiasis may be related to environmental factors such as a significant proportion of children in day care settings where this infectious disease is more readily spread.

Table 8: Most Common Reported Infectious Diseases in Infants and Children Aged 1-9, Virginia 1998

Most Common Reported Infectious Diseases					
	Number	Rate		Number	Rate
Infants			Aged 1-9 Years		
Salmonellosis	130	144.7	Salmonellosis	298	35.8
Campylobacteriosis	29	32.2	Giardiasis	162	19.5
Aseptic Meningitis	26	28.9	Campylobacteriosis	98	11.8
Chlamydia Trachomatis	23	25.6	Shigellosis	87	10.5
Pertussis	19	21.1	Aseptic Meningitis	43	5.2

Source Data: Virginia Department of Health, Office of Epidemiology

Most vaccine preventable diseases greatly decreased over the past five years. Pertussis remains an exception and reports increased from 37 in 1994 to 56 in 1998. Over half of pertussis cases were in the Northwest region of the state. Among children aged 1-9, there were 8 reported cases of pertussis, 3

reported cases of mumps, and 2 reported cases of H. influenzae in 1998. A total of 1,115 chicken pox cases among all ages were also reported (Office of Epidemiology, Virginia Department of Health).

Table 9: Reported Cases of Selected Diseases, Virginia 1994-98

	1994	1995	1996	1997	1998
Commonly Reportable Diseases Among Young Children					
Salmonellosis	1,135	1,358	1,229	1,120	1,135
Giardiasis	337	318	405	465	503
Campylobacteriosis	824	648	790	644	700
Shigellosis	656	412	746	416	200
Aseptic Meningitis	337	780	234	262	240
Vaccine Preventable Diseases					
Chicken Pox	2,844	2,667	1,778	1,760	1,115
Mumps	48	28	19	21	13
Measles	3	0	3	1	2
Pertussis	37	31	108	59	56
H. Influenzae	22	28	11	15	19

Source Data: Office of Epidemiology, Virginia Department of Health

In 1998, 1,583 children in Virginia were found to have an elevated blood lead level. An estimated 217,000 homes in Virginia have dust lead levels exceeding the old HUD standard. A 1999 statewide survey revealed that 42 percent of respondents could not name any childhood lead poisoning prevention step. Sixty-five percent (65 %) of respondents with children under age 6 said their health care provider had never talked to them about childhood lead poisoning .

In FY 98, 9,816 children of all ages were found by the DSS to be abused or neglected. Of these children, 36 died from the abuse or neglect. A disproportionate number of abused/neglected children were found in one-parent households and among black children. Of the cases of abuse/neglect, 43 percent occurred in two-parent households, 40 percent in one-parent households, and 3 percent in out of family settings. Of the victims, 51 percent were white, 40 percent were black, and 3.9 percent were Hispanic. Definition issues deter meaningful analysis of Virginia trends and national comparisons.

Data on nutrition status and eating habits are not available for the entire population. Among children receiving WIC benefits in 1999, approximately 80 percent had poor eating habits, 18 percent were obese, 12 percent were short in height for their age, and 9 percent were anemic. Pilot projects have identified activity level and poor diet as problems in the WIC population. Less than 50 percent of the children met recommendations for vitamins A and C, less than 25 percent met recommendations for dairy foods and fruits and vegetables, and 0 percent met recommendations for breads/grains. These children ate an average of 8.6 snack foods per day that are high in fat and/or sugar.

A wide variety of developmental disorders affect up to 10 percent of the childhood population, depending on the definition. Many developmental disorders originate in the perinatal period.

Prevalence estimates of chronic conditions requiring special health care for Virginia children (aged 0-20) show serious emotional disturbances affecting the most numbers (Table 10, next page). With lack of consensus on diagnostic criteria, estimates of attention deficit disorder vary between 3 percent and 7 percent of the childhood population. Juvenile rheumatoid arthritis is more prevalent in girls. Leukemia is more prevalent in younger children. Sickle cell anemia is more prevalent among African Americans. Hemophilia affects boys only.

Table 10: Estimates of the Number of Children with Special Health Care Needs by Diagnosis, Aged 0-20 Years, Virginia

Condition	Estimated number of children
Serious emotional disturbance	75,000
Hearing impairment	67,000
Asthma	48,000
Congenital heart disease	14,000
Attention deficit disorder	5,800-14,000
Juvenile rheumatoid arthritis	5,800
Leukemia	5,800
Seizure disorders	4,800
Cerebral palsy	4,800
Maxillofacial anomalies	2,900
Diabetes	2,300

Muscular dystrophy	1,200
Spina bifida	770
Autism	770
Sickle cell anemia	650
Cystic fibrosis	390
HIV/AIDS	230
Hemophilia	140

Data Sources: Henry Ireys, PhD; Department of Mental Health, Mental Retardation, and Substance Abuse; and Division of HIV/STD, Virginia Department of Health

Overview: School Age Children

The middle childhood/elementary school years are relatively healthy, a period of transition between the health issues of early childhood and those of adolescence. As with young children, the health of Virginia's school age children and adolescents continues to improve as measured by declining rates of death and reported infectious diseases as well as teen pregnancies and school absences. Virginia lacks recent population-based data on youth behavior risk factors. However, focus groups with adolescents identified drugs, sexuality, violence, mental health, and tobacco use to be significant health issues for youth from their own perspective. Most (93 percent) of Virginia school age children are judged by their parent to be in excellent or good health. Sixty-eight percent of school aged children live with a married parent, the same percentage as young children. However, most unmarried parents of older school age children are divorced, rather than single as with younger children.

Parents reported that 93 percent of children aged 6-9 and 87 percent of older children missed 10 or fewer days of school due to illness or injury (Virginia Children's Health Access Survey, 1999). According to the Department of Education (DOE), 78 percent of public school elementary school children, 72 percent of middle school children, 66 percent of high school children, and 57 percent in special education were absent fewer than 10 days of school for all causes in SY 1996-97. Since 1990-91 attendance has improved in all grades.

Parents identified 18 percent of children aged 6-9 and 25 percent of children aged 10-18 as having special health care needs. In 1998, more than 150,000 students aged 3-22 served by public schools

were found eligible under the Individuals with Disabilities Education Act (IDEA). Schools identified health impairments in approximately 7 percent of these students.

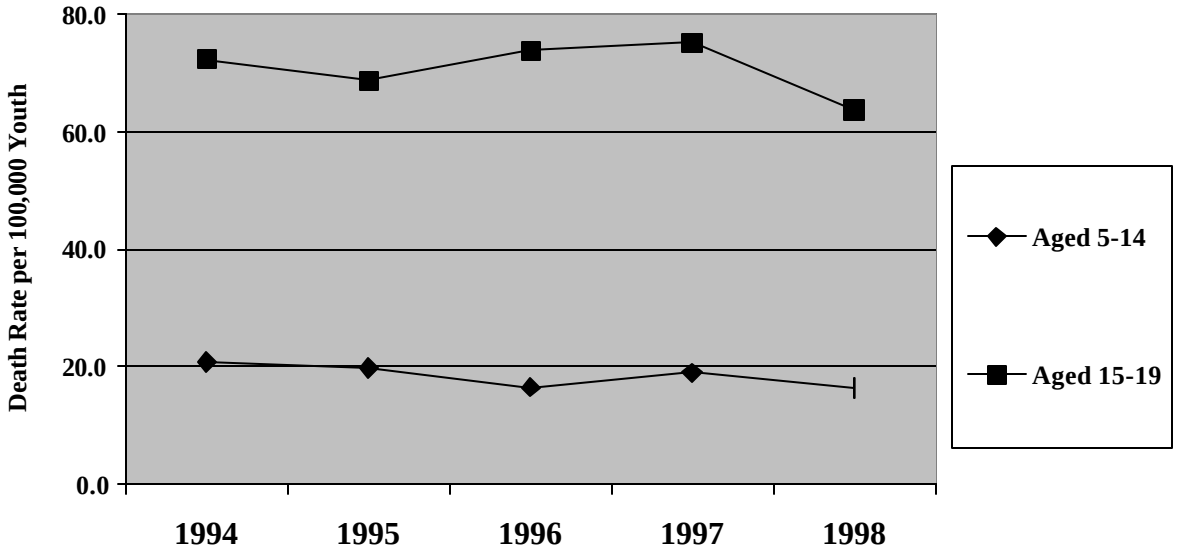
In 1998, there were 66 deaths of children aged 5-9, 92 deaths of children aged 10-14, and 297 deaths of children aged 15-19. Unintentional injuries caused the most deaths in all age groups. During the middle childhood years, congenital anomalies and diseases of the heart, leading causes of death in early childhood, move down in the ranking. By late adolescence, suicide and homicide are the second and third leading causes of death (Table 11, next page). (Virginia Center for Health Statistics). Among the black population, however, homicide is the leading cause of death among youth aged 15-19. Declining 20 percent since 1994, death rates per 100,000 school aged children were 16.5 (aged 5-14) and 63.7 (aged 15-19), respectively (Chart 14, next page). Fewer motor vehicle deaths among teens are a major contributing factor.

Table 11: Leading Causes of Death for Children Aged 5-14 and 15-19, Virginia 1998

Leading Causes of Death by Age Group	Total		White		Black	
	Number	Rate	Number	Rate	Number	Rate
Aged 5-14 Years						
Unintentional Injury	70	7.3	48	6.9	21	9.1
Malignant Neoplasms	19	2.0	14	2.0	4	1.7
Diseases of the Heart	10	1.0	6	0.9	4	1.7
Suicide	8	0.8	6	0.9	0	
Homicide/Legal Intervention	7	0.7	1	0.1	3	1.3
Aged 15-19 Years						
Unintentional Injury	130	27.9	107	31.4	17	15.8
Suicide	50	10.7	40	11.7	9	8.4
Homicide/Legal Intervention	47	10.1	8	2.3	39	36.4
Diseases of the Heart	13	2.8	5	1.5	8	7.5
Malignant Neoplasms	10	2.1	9	2.6	1	0.9

Source Data: Virginia Center for Health Statistics

Chart 14: Rates of Death for Children Aged 5-14 and 15-19, Virginia 1994-98

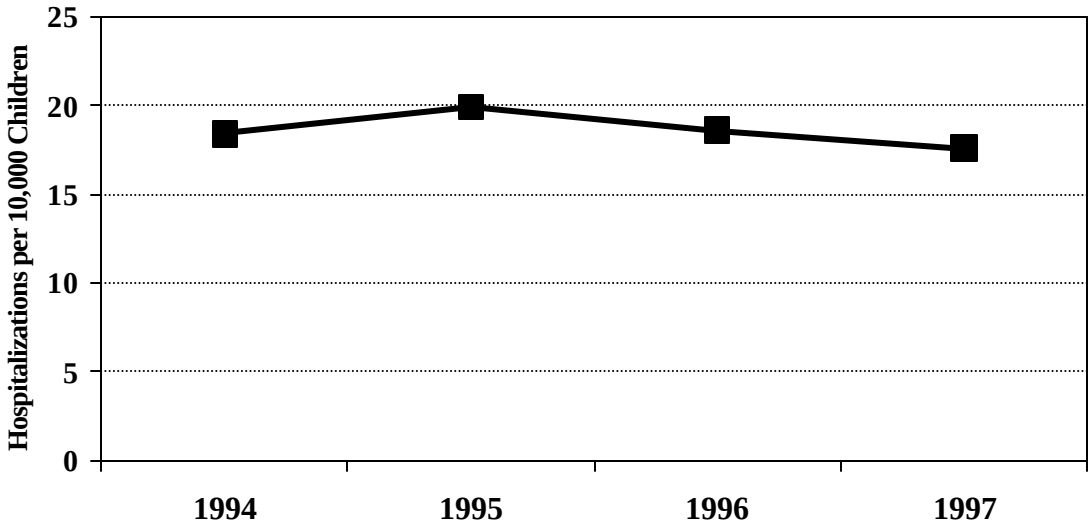


Source Data: Virginia Center for Health Statistics

Respiratory diseases, now dominated by asthma, continue to be a major cause of hospitalizations throughout the school age years. They are exceeded by injury and poisoning and mental disorders beginning with the 10-14 age group. Pregnancy is the leading cause of hospitalization in the 15-19 age group (Center for Injury and Violence Prevention).

Despite declines over the past decade, injury remains the leading cause of death and a major cause of hospitalization among school age children (Chart 15). Two-thirds of the school age injury deaths and one half of the school age injury hospitalizations are in the 15-19 year age group. In a 1996 survey, 87 percent of parents reported talking with a child aged 10 years or older about safety in the past 30 days (Virginia BRFFS, 1996).

Chart 15: Hospitalization Rates from Unintentional Injuries, Aged 1-14, Virginia 1994-97



Source Data: Virginia Department of Health, Center for Injury and Violence Prevention

Motor vehicles accounted for 69.5 percent of the 200 unintentional injury deaths among school age children in 1998. Properly used, car safety restraints reduce the risk of death from motor vehicle crashes. One-half of observed occupants aged 4-16 in metropolitan and mid-size cities correctly used car safety restraints in 1998, an increase from 1997 (Center for Injury and Violence Prevention). With motor vehicle death rates of 3.9 (per 100,000 children aged 5-14) and 24.7 (per 100,000 adolescents aged 15-19), Virginia has met Healthy People 2000 objectives for these age groups.

Firearms are the second leading method of injury deaths in the school age population. The State Child Fatality Review Team (CFRT) reviewed all of the 53 firearm deaths of children and youth in 1994, most (94 percent) of which were in the school age population. The study included 29 homicides, 21 suicides, 12 unintentional injury deaths, and one death due to legal intervention. The majority of firearm victims were adolescents aged 14-17 and were disproportionately male and black. The firearm homicide rate among black males aged 15-17 was over 20 times that of white males. The firearm suicide rate among white males aged 15-17 exceeded that of black males.

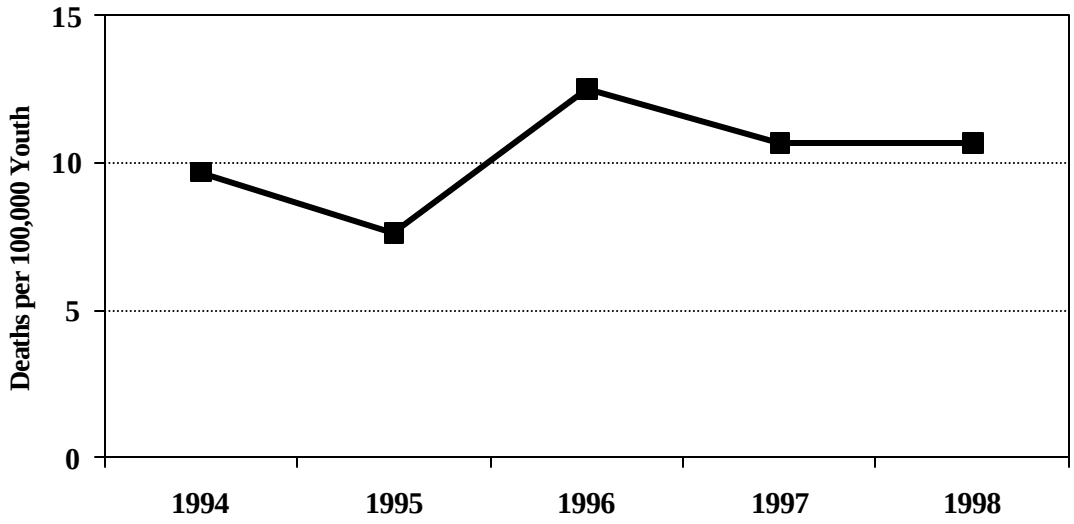
A household firearm was used in 54 percent of the reviewed deaths. One-fourth of the deaths resulted from children or youth playing with or handling firearms. Handguns were the most frequently used firearm. The Team concluded that 43 percent of these deaths were preventable. The Team found that 61 percent of the school age children had problems in school and 24 percent of the children carried a psychiatric or behavioral diagnosis before their death. Forty-six percent (46 percent) of the youth had been in the juvenile justice system for criminal charges.

Reports of public school students possessing weapons, such as guns or knives, on school property has fluctuated over the past 5 years between 2.0 and 3.0 per 1,000 students (Virginia Department of Education).

In 1998, 50 adolescents aged 15-19 committed suicide. The resulting rate of 10.7 suicides per 100,000 youth aged 15-19 was higher than the 1997 national rate (9.9) and the Healthy People 2000 objective (8.2). Since 1990, teen suicide rates (aged 15-19) have fluctuated with a low of 7.6 and a high of 12.5 in 1996 (Chart 16, next page) (Virginia Center for Health Statistics). Although white teens have higher suicide rates, the gap between whites and non-whites has narrowed. A potential indicator of suicide attempts, self-inflicted injury hospitalizations to children under age 20 numbered over 3,000 between 1994 and 1997 (Center for Injury and Violence Prevention).

The CFRT reviewed all of the 58 suicides among children and adolescents in 1994 and 1995. Boys were 2.7 times more likely than girls to commit suicide. Most (82 percent) of the suicides occurred in the home. In more than half of the cases, the child had threatened to commit suicide or had previously attempted suicide. Factors identified by the Team include: use of a firearm (62 percent), psychological or behavioral disorder diagnosis (38 percent), custody disputes (21 percent), history of child abuse or domestic violence (34 percent), involvement with the juvenile justice system or law enforcement (33 percent), below average school performance (47 percent), and receipt of mental health services (49 percent). More than half of cases were deemed preventable by the Team.

Chart 16: Rates of Suicide Among Youth Aged 15-19, Virginia 1994-98

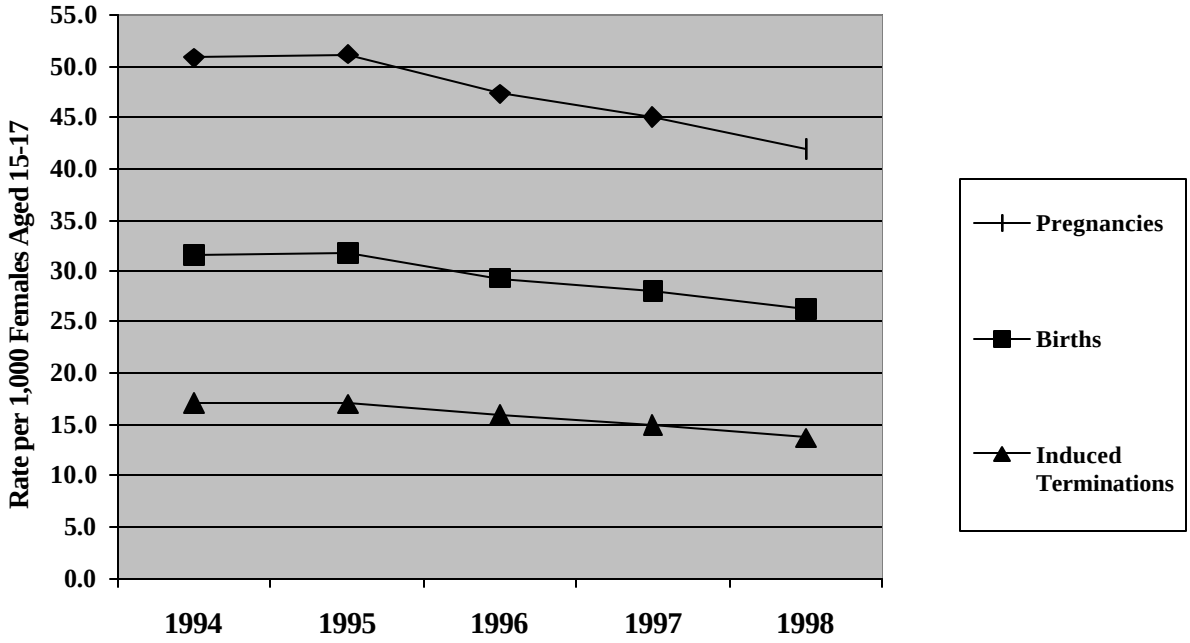


Source Data: Virginia Center for Health Statistics

The suicide rate is one indicator of mental health concern. Depression is the leading cause of hospitalization among youth aged 10-14 and is exceeded only by childbirth and unintentional injuries in the 15-19 age group (Center for Injury and Violence Prevention). There are an estimated 75,000 children of all ages in Virginia with serious emotional disturbance (Department of Mental Health, Mental Retardation, and Substance Abuse Services).

The pregnancy rate for teens aged 15-17 decreased over the past five years to 41.9 per 1000 females in 1998, exceeding the Healthy People 2000 objective of 50 per 1000. However, the black teen rate (82.6) remained more than double that in white teens (29.9) in 1998 (Virginia Center for Health Statistics). Both teen birth and induced termination rates have declined annually in the past five years. The birth rate among those aged 15-17 declined 17 percent in the past five years, while the induced termination rate declined 19.4 percent over the same time period (Chart 17, next page). In a 1996 household survey, 61 percent of parents reported that they had talked with their children about sexual behavior in the past 30 days (Virginia BRFFS, 1996). Recent statewide data on sexual behavior among Virginia's youth are not available.

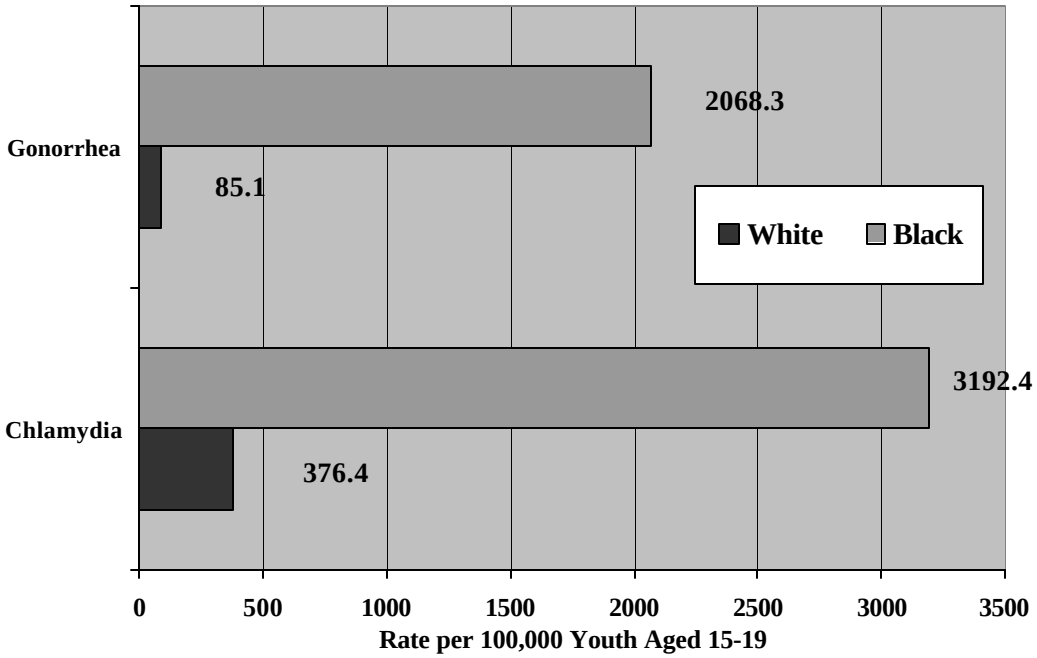
Chart 17: Teenage Pregnancies, Births, Induced Terminations Among Females Aged 15-17, Virginia, 1994-98



Source Data: Virginia Center for Health Statistics

While rates of reported sexually transmitted diseases have declined since the early 1990s, chlamydia and gonorrhea comprise the most common reportable diseases in the school age population. More of these cases are reported among 15-19 year olds than any other age group. In 1998, there were 2,274 reported cases of chlamydia per 100,000 females aged 15-19. The gonorrhea rate of 610 cases per 100,000 adolescents aged 15-19 meets the Healthy People 2000 objective (Division of HIV/STD, Virginia Department of Health). Minority youth rates remain a concern, particularly among blacks, as they are significantly higher than whites (Chart 18).

Chart 18: Rates of Chlamydia and Gonorrhea per 100,000 Youth



Aged 15-19 by Race, Virginia 1998

Source Data: Virginia Department of Health, Division of HIV/STD

A 1996 Virginia household survey asked if the parent had talked with a child aged 10 years or older in the past 30 days about health behaviors. Sixty-two percent (62 percent) reported that they had talked about smoking, 28 percent about smokeless tobacco, 67 percent about alcohol, and 76 percent about drugs (Virginia BRFFS, 1996). Recent data on tobacco, alcohol, and illicit drug use by Virginia's youth are not available.

The Division of Dental Health is conducting a needs assessment covering fluoridation, dental caries, and oral hygiene. These results are currently being finalized. Preliminary results of the Statewide Dental Needs Assessment conducted on a representative sample of 1st, 3rd and 10th grade students showed a significant difference in the oral health of certain children. Mirroring the results seen nationally regarding oral health, children of racial and ethnic minority groups as well as those of lower socioeconomic status are showing a disproportionate level of dental disease as compared to other groups. Preliminary results

also show an increase in the disease rate in primary teeth of study participants compared to previous studies.

A survey of Virginia fourth graders revealed that 34 percent of children are overweight and not engaged in adequate physical activity. Based on national food surveys, an estimated 88 percent of teen girls and 68 percent of teen boys consume less than the daily recommendation for calcium. Poor calcium nutrition in childhood is linked to the development of osteoporosis in older adults.

In a series of focus groups, Virginia parents of fourth graders identified time and convenience as critical barriers to healthy behaviors in their children. They expressed concerns that children do not have safe environments for play. Children's comments provided strong evidence of media influence and an inclination toward sedentary behaviors such as viewing television, videos, or computers instead of physical activity. The perception that healthy foods do not taste good was often expressed (*Report on the Child Nutrition Focus Group Project, 1998)*. In a 1996 household survey, parents reported talking about health behaviors related to nutrition (86 percent) and exercise (77 percent) with their children of any age in the past 30 days (Virginia BRFFS, 1996).

Prevalence estimates for chronic conditions among children of all ages are presented above in the Early Childhood section.

3.1.2.2 Direct Health Care Services and
3.1.2.3 Enabling Services

Title V funded direct services through local health departments such as family planning, prenatal care, and well child care continue to be offered and utilized by a sizable proportion of the maternal population. Services to children with special health care needs (CSHCN) also are delivered through health department managed Children's Specialty Service and Child Development Clinics. With the advent of managed care and overall falling numbers of Medicaid clients, however, the health service delivery system has been altered with fewer health department clinics and increased private sector providers.

Health departments do however, remain an important safety net for the uninsured. Health departments continue to largely maintain or increase their roles as enablers to services. Programs providing mentoring and case management to pregnant teens, fathers, and families with children largely have grown in the past five years.

Access to services remains highly dependent on insurance coverage. Children and women without insurance are least likely to access early and preventive services. The uninsured are more likely to be minorities, poor, and from single parent families. While the proportion of uninsured children has decreased, great concerns remain over the underutilization of Children's Medical Security Insurance Plan (CMSIP). In addition, the proportion of uninsured women has increased, a probable result of welfare reform, dropping Medicaid rolls, and inability to purchase private insurance due to cost or other factors.

While Virginia has an overall sufficient number of primary, preventive, and specialty service providers, they are unevenly distributed throughout the state. Regional differences affect access with Southwest and South Central Virginia, and the Eastern Shore consistently exhibiting provider shortages or other underserved qualifications.

Cultural competency has emerged as a critical issue for health systems to meet the needs of growing minority and multicultural populations. Adequately serving Hispanic and other non-English speaking groups has challenged language resources, however, the need to deliver services completely in culturally appropriate ways also has presented as a crucial focus. A CSHCN needs assessment also identified a need for a source of comprehensive, up-to-date information regarding available resources and programs as well as effective referral and advocacy support to link families and providers to these resources. A large unmet need identified was for support services for families with CSHCN. Recommendations were made to establish Regional Resource Centers and a statewide Family to Family Network.

Direct and Enabling: Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants.

Prenatal services in the Commonwealth are delivered primarily through private physicians. Birth certificate data indicated 74.3 percent of infants born in 1998 had mothers who received all care with a private physician. In addition, some hospital clinics, health departments, and federally funded Community and Migrant Health Centers (CHCs) help serve the uninsured and underinsured. Each perinatal region, except Southwest Virginia (Region 1), contains at least one referral center for high-risk patients.

Health departments continue to offer prenatal care in most areas. Thirty-one out of 35 health districts provide some prenatal care at 105 locations. One district, Richmond City, contracts its care with the Medical College of Virginia (MCV), a university-based hospital. Health departments provide varying degrees of services based on community need and available resources. Some follow patients for the entire pregnancy, while others conduct initial exams and assessments and then link patients with private physicians. Nine health districts utilize residents to help deliver care. An additional 11 districts work collaboratively with local private providers by using per diem services or sharing staff. In 30 communities, the health department is the only provider of prenatal care. In FY 99, health departments served 17,361 clinic prenatal patients. Three out of ten prenatal patients were teenagers (Office of Information Management, Virginia Department of Health).

Eleven federally funded Community Health Center (CHC) corporations, including one or more sites, provide some prenatal care services throughout the state. In 1998, CHCs provided prenatal services to 1,267 clients. At these clinics, 30.1 percent of prenatal patients were teenagers and 37.6 percent of all patients had no insurance (Virginia Primary Care Association).

A 1999 manpower survey conducted by RPCs identified 965.7 full time equivalent (FTE) perinatal providers statewide in public and private settings. In Virginia, 75 (55.6 percent) communities have at least one obstetrician and 35 (25.9 percent) localities have a family physician offering prenatal care. Mid-level providers, such as nurse practitioners, certified nurse midwives, and physicians' assistants, were 14.3 percent of the provider base and practicing in 93 (68.9 percent) localities. The survey found a ratio of 1:95 for perinatal providers to births (*Perinatal Underserved Areas in Virginia, 1999*). Although the total perinatal FTEs are adequate, their distribution is uneven throughout the state.

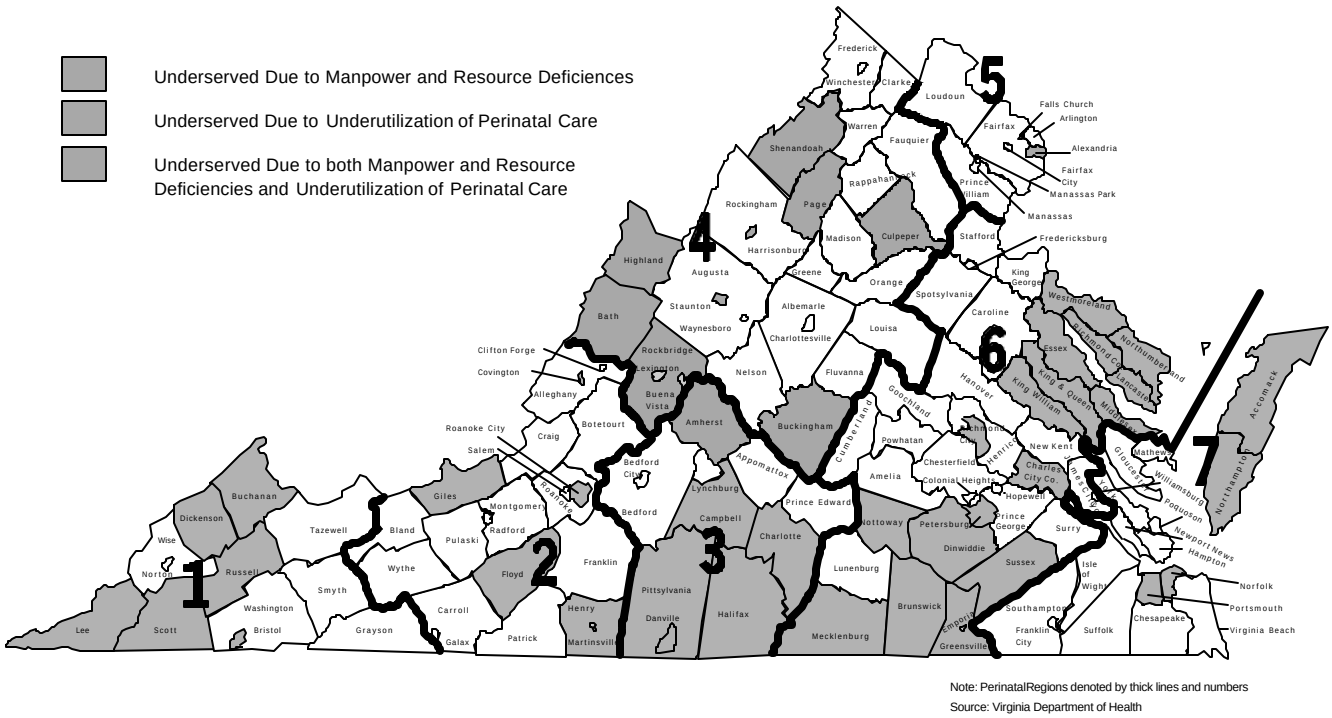
Following an initial 1997 legislative study, VDH, in conjunction with RPCs, updated perinatal underserved designations in 1999 and 52 communities (38.5 percent) met the established criteria. Recognizing that both acceptability and availability of care impact utilization, the concept reflects areas in need related to resources as well as underutilization. In 1999, 21 communities were perinatal underserved due to manpower and resource deficiencies (Table 12, next page). These areas had either a FTE prenatal provider shortage along with a 45-minute one way travel time to care or had no labor and delivery facility within an hour's drive. Localities with manpower and resource deficiencies were concentrated in the most rural Regions of 1, 3, and 4, as well as, the rural areas of Regions 6 and 7 (Map 3, next pages). One third of communities in Southwest (Region 1) and South Central (Region 3) Virginia had manpower and resource deficiencies (*Perinatal Underserved Areas in Virginia, 1999*).

Nearly twice the amount with resource deficiencies, 40 communities were underserved due to underutilization. In these localities, the late/no entry into prenatal care proportion was 1.5 times the state level or they had a combination of a late/no entry rate worse than the state and selected birth outcomes varied over 25 percent from the state. Selected birth outcomes were based on five-year data for perinatal mortality, low weight births, and congenital anomalies. Most communities (n =27) with underutilization were designated because their late/no entry into care rates were 1.5 times worse than the state. Thirteen communities had a combination of poorer prenatal care utilization with high birth outcome variances. These areas included both rural and urban communities spread among all perinatal regions. Central Virginia (Region 6) had the largest number of localities with underutilization. Nine communities were underserved in both categories.

Table 12: Perinatal Under Served Areas: Virginia 1999		
Region	Manpower and Resource Deficiencies	Underutilization (late entry into care and poor outcomes)
Southwest (Region 1)	Buchanan* **Dickenson *** Russell Scott*	Bristol **Dickenson *** Lee*
Blue Ridge (Region 2)	Floyd	Covington Giles* Henry* Martinsville* Roanoke City
South Central (Region 3)	Amherst Campbell **Charlotte*** **Pittsylvania***	**Charlotte*** Danville Halifax* **Pittsylvania**
Region 4	Bath* Buckingham **Highland*** Page	Buena Vista Culpeper Harrisonburg **Highland** Lexington Rockbridge Shenandoah Staunton*
Northern Virginia (Region 5)		Alexandria*
Central Commonwealth (Region 6)	Dinwiddie* **Essex*** **King and Queen*** King William Middlesex **Northumberland** **Westmoreland**	Brunswick* Charles City Emporia* **Essex** Greensville* **King and Queen*** Lancaster* Mecklenburg* **Northumberland*** Nottoway* Petersburg* Richmond City* Richmond County* Sussex **Westmoreland**
Eastern Virginia (Region 7)	**Accomack**	**Accomack*** Norfolk* Northampton* Portsmouth*

* = Previously designated in 1997

Map 3:
Perinatal Underserved Areas: Virginia 1999
By Perinatal Regions and by Counties and Independent Cities



Note: PerinatalRegions denoted by thick lines and numbers
Source: Virginia Department of Health

Access to services measured by prenatal care utilization reflects the impact of health insurance. Birth certificate data showed most 1998 Virginia resident births (65.5 percent) were covered under private insurance and close to one-quarter (24.1 percent) were under Medicaid. Mothers with private insurance started care most frequently in the first trimester at 91.5 percent compared to only 71.6 percent among those with Medicaid. Later entry may be related to high-risk factors, as well as delays in obtaining Medicaid approval for services. Black mothers were more likely to have Medicaid (44.0 percent) as their insurance. Medicaid coverage was most frequent in nonmarital births (55.7 percent) and teenage births (56.4 percent) (Virginia Center for Health Statistics).

While birth certificates indicated 5.1 percent of births occurred to those without insurance, 1997 hospital discharge data showed 17.5 percent without a payment source. Discrepancies may be linked to insurance confirmation delays, however the range suggests a need for better data collection. Mothers with no payment source were least likely to obtain early prenatal care (58.0 percent) and 7.4 percent had no care at all. No insurance was more common among black (6.0 percent), unmarried (8.8 percent), and teen (9.3 percent) mothers. Nearly one-third (31.1 percent) of the 1,062 infants born without any prenatal care did not have insurance coverage (Virginia Center for Health Statistics).

Lack of health insurance negatively impacts all women. Alan Guttmacher Institute (AGI) published Census derived data showing the percent of Virginia uninsured women aged 15-44 rose from 14.6 percent in 1994-95 to 16.0 percent in 1997-98. This occurred despite the state having a statistically significant decrease in poverty and record low unemployment rates. A 1998 legislative study found that half of all uninsured persons had been offered employment related health insurance, but cost was the primary reason purchasing coverage was declined. Additionally, 26 percent of those uninsured stated they had went without needed health services in the past year *(Study of the Indigent/Uninsured Pursuant to SJR 298, 1998)*.

According to the 1999 BRFSS, females aged 18-24 were most likely to be uninsured (22 percent). The uninsured rate fell with age, as 14 percent of females aged 25-34 and 7 percent of females aged 35-44 had no insurance coverage. Cost was cited by 53 percent and insurance not offered by employer was named by 9 percent of all females as the main reason they did not have coverage. Among all BRFSS respondents (including males), the most likely to be uninsured were those without a high school education (22 percent), with annual income under $15,000 (28 percent), or minority status such as black (17 percent) or Hispanic (14 percent).

Females aged 18-24 were also most likely (26 percent) not to have a particular clinic, health center, doctor's office, or other place to go for treatment of illness or health advice according to the 1998 Virginia BRFFS. This figure dropped to 12 percent among females aged 25-34 and fell to 6 percent among females aged 35-44. While the most common reason cited for not having a regular medical

source was "haven't needed a doctor", "no insurance/can't afford" was the second most common frequently given reason. Among females aged 15-44 with a regular place for medical care, a doctor's office/HMO was the most common place cited (72 percent). This was followed by clinic/health center (16 percent), urgent care center (4 percent), hospital outpatient (3 percent), and hospital emergency room (2 percent).

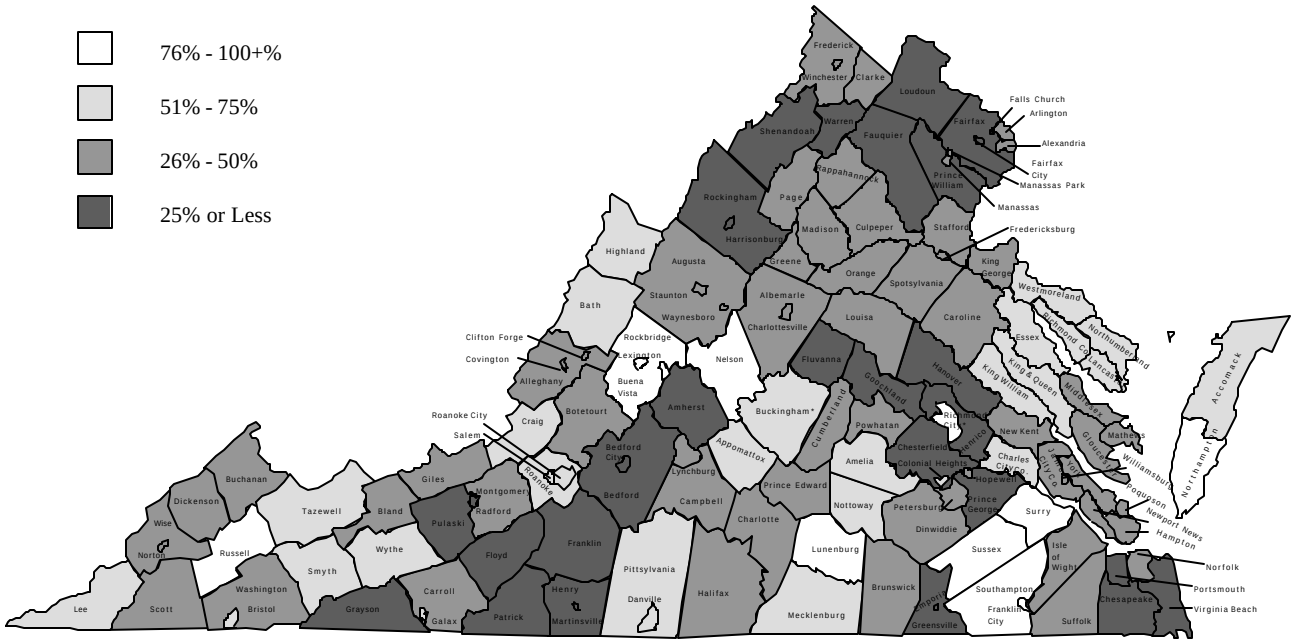
A potential mechanism to increase access to care, a proposed waiver to extend family planning Medicaid benefits for two years postpartum for Virginia women enrolled due to pregnancy, is being reviewed by the U.S. Health Care and Financing Administration (HCFA). This will continue Medicaid funded family planning services for women who would otherwise lose coverage 6 weeks after delivery and who continue to meet pregnancy eligibility requirements up to 133 percent Federal Poverty Level (FPL). The proposal, however, does not encompass other health services normally covered under Medicaid.

For many women, family planning is the only source of medical care or regular interaction with health providers. Health departments operate 143 family planning sites statewide giving all Virginians access within their jurisdiction or a nearby locality. In over half of localities, the health department is the only public low or no cost contraceptive provider. While most family planning sites are traditional clinics, there are also two mobile units, three community college sites, one Job Corps site, and one public housing site. Three cities, Alexandria, Norfolk, and Roanoke, have school-linked clinics, which provide exams and refer to health departments for contraceptives if needed. Effective contraception has significantly improved with four-fifths of female health department patients using a hormonal method including injectables. This may be an important factor in fewer teen pregnancies, as one quarter of the patients are teens.

The 1999 Title X family planning needs assessment identified areas of concern including adequately serving multicultural populations, involving males, bringing "hard-to-reach" populations into services, promoting the concept and benefits of intended pregnancy, and compensating for flat and declining resources. Funding for injectables has created tremendous resource demands. AGI estimated that two-thirds of Virginia's sexually active women (251,000 females) went without needed publicly supported

services in 1995. This was the 10th worst percentage among the 50 states. Virginia communities with the least served were often the heavily populated ones such as Northern Virginia localities (Map 4). In addition, the Sterilization Program, which provides voluntary services to low income persons, consistently expends annual state funds within three months. While 221 persons were served in FY 99, the Sterilization Program remains underutilized by men (Division of Women's and Infants' Health, Virginia Department of Health).

Map 4: Percent of Women in Need Aged 13-44 Served by Publicly Supported Family Planning Services, Virginia 1995



Source Data: Alan GuttmacherInstitute (AGI)

* = Estimated by AGI Note: Women in need include all not seeking pregnancy, sexually active, and fecund teens and women aged20-44 up to 250% of the Federal Poverty Level

In December 1999, the Virginia WIC Program served 37,100 women in local health department clinics. Of these clients, 15,411 were pregnant and 21,689 were postpartum of whom 7,946 were breastfeeding. Pregnant WIC enrollees had the following high-risk factors for low weight births: inadequate weight gain (21.8 percent), closely spaced pregnancies (13.2 percent), smoking (18.3 percent), multiple gestation (18.2 percent), and teenager at conception (9.3 percent). Other risks

identified were poor eating habits (70.2 percent), obesity (40.4 percent), previous poor pregnancy outcome (28 percent), and medical condition requiring special dietary intervention (9 percent).

Support services assisting women and families to obtain care are available through local health departments, hospitals, and other community-based agencies. Resource Mothers, a lay home visiting program, serves pregnant and parenting teens in 80 localities through 28 public and private contractors. After receiving intensive training, a resource mother acts as a mentor to encourage early and regular prenatal care, healthy behaviors such as avoidance of substance abuse and tobacco, getting immunizations on schedule, staying in school or in a job, and delaying repeat pregnancies. The resource mother contacts the teen weekly from the prenatal period through the infant's first birthday. Recognizing the importance of involving fathers, some localities have added resource fathers to work with the infant's father. The Resource Mothers Program nearly doubled its new clients from 860 in FY 95 to 1,488 in FY 99, over 95 percent of which are Medicaid or Children's Medical Security Insurance Plan (CMSIP) eligible. In addition, over 900 continuing clients were served in FY 99 (Division of Women's and Infants' Health, Virginia Department of Health). The Program receives $517,000 in Medicaid administrative funds, which are supplemented by Title V and state funds. Program enrollment reflects race and ethnicity of localities' low income populations. Resource Mothers clients have demonstrated lower rates of low weight births and repeat pregnancies than teen parents across the state.

Unmet needs include expansion of existing programs to serve additional teens requesting services and expansion to young adults (aged 20-24) who are currently unserved except in nine Healthy Start localities. Under current capacity, 14.7 percent of all pregnant teens were served in 1998 which falls short of existing needs. Three additional communities have requested support in starting Resource Mothers.

Case management for high-risk pregnant women and their infants is available in nearly all (34) health districts. Medicaid reimburses case management services for eligible pregnant women and infants up to two years of age under the Baby Care Program, which is available at health departments in all but four districts. In FY 99, 3,669 pregnant women and 5,043 infants received VDH case management services which includes risk screening, care coordination, medical nutrition, therapy assessment and counseling,

homemaker services, and patient education as warranted (Office of Information Management, Virginia Department of Health). CHIP, Comprehensive Health Investment Program and Healthy Families, two other family-centered case management programs, which often serve pregnant women and infants, are discussed under direct and enabling services for children.

Virginia Healthy Start Initiative (VHSI) currently exists in nine communities. Designed to reduce infant mortality and its contributing factors such as low birth weight, this federally-funded ($1.8 million Healthy Start) health department initiative has expanded enabling services such as Resource Mothers to serve young adults aged 20-24 and to provide male mentors to fathers. VHSI has also provided medical nutrition therapy services for high-risk pregnant women and infants through the Nutrition Intervention Program for Underweight Pregnant Women (NIP). This model was replicated in 1999 through a separate Healthy Start federal grant ($1 million) to reduce racial and ethnic disparities in three localities. In FY 99, 752 women were served in the expanded Resource Mothers Program and NIP in the six initial VHSI sites. Male mentors were provided for 237 clients The VHSI works closely with the Virginia Fatherhood Campaign. (Division of Women's and Infants' Health, Virginia Department of Health).

Local Community Service Boards (CSBs) provide substance abuse services. Five localities have Project LINK, a case management program for substance abusing pregnant women, mothers and their infants. This collaborative program provides on-site services at local health departments. Designed by VDH, Department of Mental Health, Mental Retardation, and Substance Abuse (DMHMRSAS), and the Virginia Cooperative Extension, the program began in 1991 through a combination of federal funds. While areas such as Richmond, Roanoke, and Tidewater have outpatient and/or residential treatment centers for women, which include pregnant and postpartum clients, the existing supply is not adequate for the need. Perinatal substance abuse programs continue to be an unmet need in many areas.

Nearly three-quarters of hospitals have a community outreach program for prenatal care services. Many offer other support services, which may include case management, school-based outreach, incentive programs, education and hot line availability. One quarter reported having hospital based outreach

workers. Substance abuse services were available in 23.8 percent of facilities (Virginia Health Information).

Although several case management programs exist statewide, the need for better care coordination and increased resources to adequately serve those in need has been identified by numerous groups including the RPCs. No formal statewide mechanism exists to link all case management programs. Many communities still do not have some of these programs, which help improve health by strengthening families, or program staffing may not be sufficient to meet demand.

Direct and Enabling: Preventive and Primary Care Services for Children

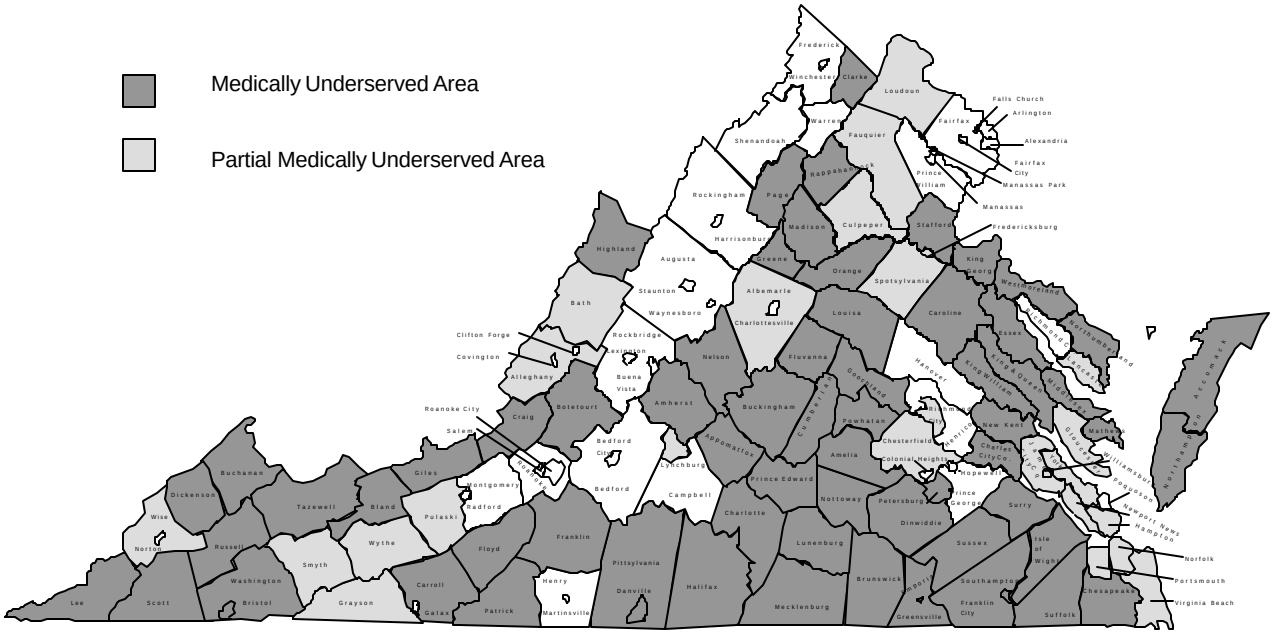
While the primary care system is generally strong, Virginia falls short of the Healthy People 2000 target of 95 percent for children having a specific source of primary care. In a 1999 statewide survey, parents reported that 75 percent of children have a specific place to go for both preventive health and illness care (medical/health home). Most (84 percent) of the children with a medical/health home go to a doctor's office, private clinic, or HMO. Other sources include hospital outpatient clinics (3 percent), military health care facilities (3 percent), school health centers, and CHCs. An additional 17 percent of children have a usual source of sick care. Children with a usual source of sick care but lacking a medical/health home are less likely to receive care in a doctor's office or private clinic (50 percent) and more likely to receive care in a hospital outpatient clinic (6 percent) or hospital emergency room (7 percent). Six percent of Virginia children have no usual source of sick care. Three percent (3 percent) of all survey respondents reported that they had not been able to get needed care for their child in the past year. The most frequent reason for not getting care was not being able to afford it, followed by the inability to get an appointment when needed (Virginia Children's Health Access Survey, 1999).

Access to care is associated with health insurance coverage. Uninsured children in Virginia, compared to insured children, were more likely not to have a medical/health home (49 percent vs. 21 percent), not to have a usual place for sick care (26 percent vs. 4 percent), to use a place other than a doctor's office for

sick care (52 percent vs. 20 percent), and to have been unable to get needed care at a time in the past year (15 percent vs. 2 percent) (Virginia Children's Health Access Survey, 1999).

The ratio of primary care physicians to the total population in Virginia is better than the national ratio. The 1996 ratio of pediatricians providing direct patient care to children in Virginia of 1:1,344 also compares favorably with the national ratio of 1:1,483 (American Academy of Pediatrics). This ratio varies significantly across the state. Northern Virginia has the most favorable ratio, whereas the Roanoke and Southwest Regions lag behind. Of Virginia's 135 counties, 95 are either totally or partially designated by the U.S. Bureau of Primary Care as Medically Underserved Areas (Map 5, next page). Virginia's network of 42 Community and Migrant Health Centers (CHCs), designed to reach underserved areas served 39,662 children (aged 0-19) in 1998 (Virginia Primary Care Association).

Map 5: Medically Underserved Areas (MUA) in Virginia, 1998



Source Data: VDH, Office of Primary Care. Designations are made by through the U.S. Bureau of Primary Care

School-based health centers provide, at a minimum, primary and preventive health care, mental health counseling, health promotion, and referral and follow-up services to enrolled students. In SY 1998-99, there were 28 school-based health centers serving 32 of the 132 school divisions. The centers receive funding from a variety of sources.

The primary role of school nurses in Virginia is to support student learning by implementing strategies for health and safety promotion. This encompasses serving as the health services coordinator, conducting health screenings, providing emergency first aid, teaching health education and promoting wellness activities, administering medications, and providing specialized health care procedures and chronic disease management for children with special health care needs. In 1999, 48 percent of school districts met or exceeded the state target ratio of one school nurse per 1,000 students, up from 35 percent in 1996. School nurses are employed by local school divisions (81 percent), local health departments (16 percent), and other agencies (2 percent) (Virginia Departments of Health and Education).

Preventive health services are provided at all local health departments, although specific services and ages served vary among localities. The *Code of Virginia* mandates local health departments to provide immunizations, school entrance exams, and treatment for sexually transmitted diseases. Reproductive health services for adolescents are discussed above. Alexandria, Central Virginia, Norfolk, and Hampton Health Districts continue to provide comprehensive primary care for children.

Despite having a medical/health home, some children do not receive recommended preventive care. Among children with a medical/health home, parents reported that 80 percent received a routine physical exam within the past year. All Medicaid and CMSIP recipients are assigned a primary care provider. DMAS program data documents only 20 percent of children with Medicaid received a 1999 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screen, which falls below the 1997 national rate of 28 percent and national goal of 80 percent.

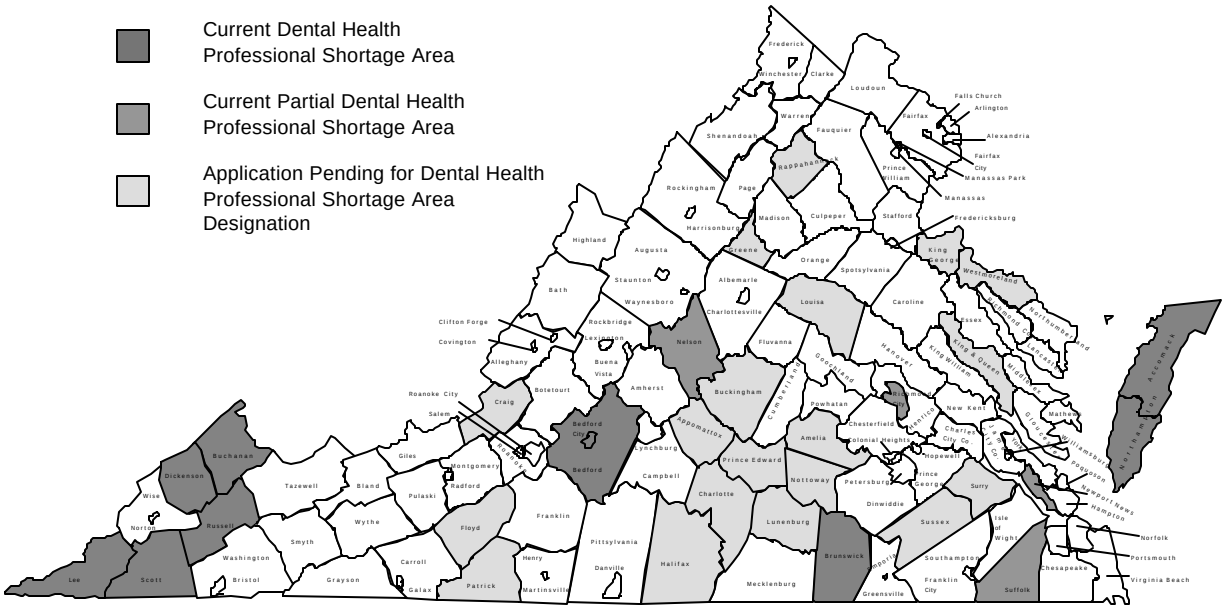
Immunization rates and asthma hospitalizations are two measures of access to and the quality of primary care services. An estimated 80 percent of two-year-old children were fully immunized in 1998 (Virginia

Child Health and Immunization Survey, 1998). Although near the national rate, Virginia's rate is below the Healthy People 2000 objective of 90 percent. Virginia's rate of asthma hospitalizations among children under 5 was 50 per 10,000 children in 1997, which is close to the national rate. However, Virginia's rate for black children of all ages is about 3 times that for white children.

One-fourth of Virginia children do not receive recommended dental care, and services are unavailable for many low-income children. In 1999 approximately 15 percent of children aged 2 or older had never received dental care, and an additional 11 percent had not received dental care within the last 12 months (Virginia Children's Health Access Survey, 1999). Only 18 percent of all children and 25 percent of school age children enrolled in Medicaid received dental services documented by DMAS for 1999.

While the dentist to population ratio in Virginia approximates the national average, 30 percent of cities and counties have a ratio greater than the current measure for a federally designated Dental Health Professional Shortage Area (HPSA) (Map 6). The number of dentists providing Medicaid fee-for-service care declined 36 percent from 1991 to 1998. As of 1998, 681 dentists and 88 dental clinics provided some Medicaid services for children not enrolled in capitated plans (Virginia Department of Medical Assistance Services). To increase Medicaid dentist participation, the 1998 Appropriations Act directed DMAS to develop reimbursement rates based on commercial insurer data to raise fees to the

Map 6 : Dental Health Professional Shortage Areas, Virginia 2000



85th percentile of usual and customary rates. Most (28) local health districts provide some dental services for the low income population and they provided 57,950 dental visits to children aged 1-18 in FY 99 (Office of Information Management, Virginia Department of Health).

Prior to significant CMSIP enrollment, an early 1999 population-based survey found that nearly two-thirds (64 percent) of Virginia children were covered by comprehensive health insurance (physician visits, hospitalization, dental, mental health, and prescription drugs). Another (23 percent) had basic coverage (physician visits and hospitalization), and a few (3 percent) had only specialty coverage. Ten percent did not have any health insurance, which represented a drop from an earlier 1996 survey. Of the insured children, most (68 percent) were covered by a private insurance source obtained through a parent's job or union and 15 percent had Medicaid coverage. An estimated 7 percent of all children were eligible for Medicaid or CMSIP but not enrolled. Virginia's uninsured children are more likely those with insurance to be African-American (45 percent vs. 22 percent), to live with an unmarried parent, most frequently the mother) (53 percent vs. 22 percent), or to live in a household with an income below 185 percent FPL (78 percent vs. 27 percent) (Table 13, next page) (Virginia Children's Health Access Survey, 1999).

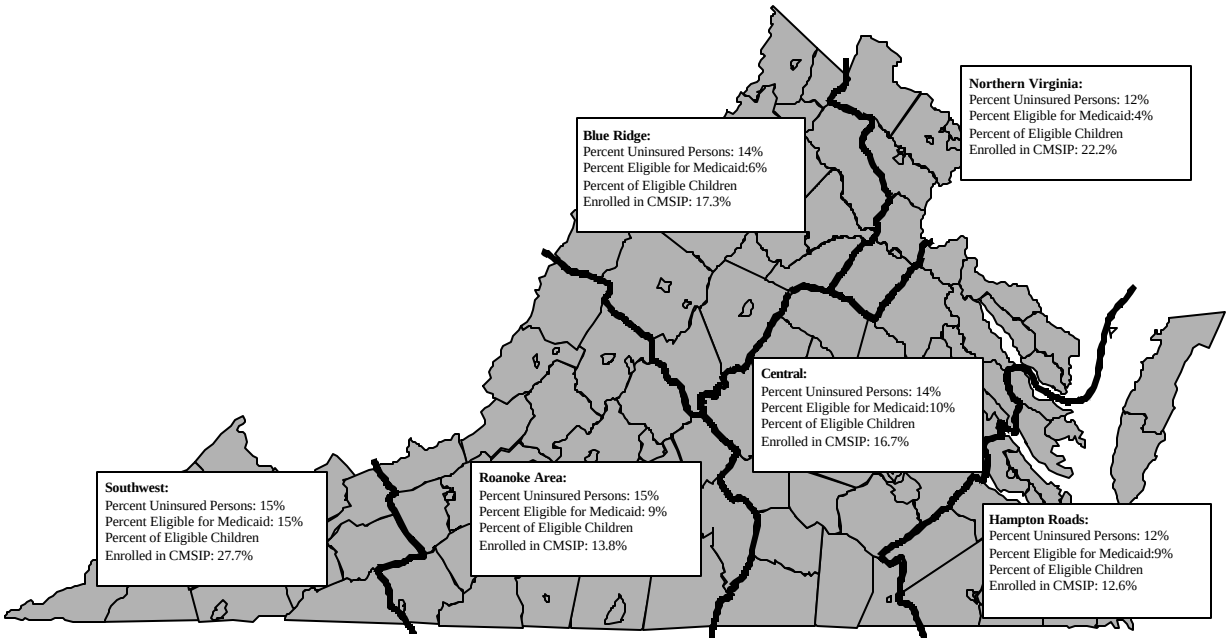
The Virginia Medicaid Assistance Program (Medicaid/Title XIX) covers children aged 0-5 in families with incomes up to 133 percent FPL and children aged 6-18 up to 100 percent FPL. In FY 99, 405,027 children (aged 0-20) were enrolled in Medicaid, 52 percent of whom were black, 14 percent white, and 7 percent other races (Virginia Department of Medical Assistance Services). Coverage for preventive services under EPSDT is more limited than some recommended schedules. While the American Academy of Pediatrics and Bright Futures recommend annual preventive health visits for adolescents, EPSDT provides for biennial visits after age 6. While the American Dental Association recommends children see a dentist by their first birthday, EPSDT coverage for routine care begins at age 3.

The Virginia Children's Medical Security Insurance Plan (CMSIP/Title XXI) currently provides Medicaid-equivalent benefit coverage for uninsured children in families up to 185 percent FPL who have

been without health insurance coverage for the past 12 months and who are not eligible for Medicaid or the state employee health insurance plan. Although 72,000 children were estimated to be eligible, CMSIP enrollees numbered only 19,569 at the end of 1999 (Virginia Department of Social Services). Identified barriers to enrollment include the perception that CMSIP is a "welfare" program and a

Map 7: Insurance Status Indicators

by Health Maintenance Regions, Virginia 2000



NOTE: ALL FIGURES ARE REGIONAL MEDIANS
Percent Uninsured Persons (1997), Percent of Population Eligible for Medicaid (1998)
Source Data: Virginia Hospital and Healthcare Association: *Indicators of Health Communities 2000*

complicated application process. Local departments of social services (DSS) responsible for the enrollment process vary significantly in commitment and enrollment rates. Regionally, Southwest Virginia has the highest proportion of CMSIP eligibles enrolled, while Eastern Virginia has the lowest proportion according to data published by the Virginia Hospital and Health Care Association (Map 7).

Table 13: Profile of Virginia Uninsured Children

	Insured	Uninsured	Total
	Percent	Percent	Percent
Does child have medical home?			

Yes	79%	51%	76%
No	21%	49%	24%
Usual source of sick care			
Doctor's office or private clinic	80%	49%	77%
Hospital outpatient clinic	4%	5%	4%
Military health care facility	3%	0%	3%
Some other kind of place	2%	5%	2%
HMO/Prepaid group	2%	2%	2%
Hospital emergency room	2%	4%	2%
Company or school health clinic/center	2%	5%	2%
Community/migrant/rural clinic/center	1%	0%	1%
Local public health department	0%	2%	0%
Free or other non-profit clinic	0%	2%	0%
No place to go, never got care, don't know	4%	26%	6%
Within the past year, was there a time when your child needed health care, but was unable to get it?			
Yes	2%	15%	3%
No	98%	85%	97%
Respondent's marital status			
Married	70%	47%	68%
Not Married	30%	53%	32%
Child's age			
Under 18 years old	98%	95%	98%
18 years old	2%	5%	2%
Child's race			
White	69%	45%	66%
African-American	22%	45%	24%
Other	9%	10%	10%
Household poverty status			
Below 100% of poverty	10%	30%	12%
100%-132% of poverty	6%	18%	7%
133%-149% of poverty	3%	4%	3%
150%-184% of poverty	8%	26%	10%
185%-199% of poverty	4%	2%	4%
200% or more of poverty	69%	20%	64%

Source: 1999 Virginia Children's Health Access Survey, Virginia Commonwealth University-Survey and Evaluation Research Laboratory

To reduce barriers and increase enrollment, CMSIP will be replaced by the Family Access to Medical Insurance Security Plan (FAMIS), as mandated by SB 550 in the 2000 Virginia General Assembly

pending approval of a federal waiver submitted July 2000. FAMIS will increase coverage to children in families up to 200 percent FPL who do not qualify for Medicaid and have not had health insurance coverage for the past 6 months. FAMIS will provide premium assistance to participants who have access to employer-sponsored health insurance if deemed cost effective. Wrap-around services such as dental, vision, mental health and substance abuse will be provided if not part of regular employer coverage. FAMIS will include some cost sharing with limits based on FPL. State administration will differ from CMSIP and be within one centralized processing site to be managed by DMAS. The application form has been shortened to one page. Local social service agencies, contracting health plans, providers and others will be able to provide application assistance and enroll children in FAMIS or Medicaid as appropriate.

The law also mandates establishing an Outreach Oversight Committee (OAC) composed of representatives from community-based organizations, health plans, social services eligibility workers, providers, and consumers to make recommendations on state-level outreach activities, coordination of regional and local outreach activities, and procedures for streamlining the application process, forms, and correspondence. Title V staff will serve on the OAC. As mandated by law, the Outreach Plan must include specific strategies for improving outreach and enrollment in localities having less than statewide average enrollment and enrolling children of former TANF recipients.

Local health departments currently collaborate with other community partners to increase awareness and encourage all potentially eligible health department program participants to apply for Medicaid and CMSIP. The health department is expected to play an important role in FAMIS outreach. SignUpNow, a three-year private sector initiative of the Virginia Coalition for Children's Health, supports community-based efforts to identify and enroll eligible children in Virginia's health insurance programs.

The State budget supports several prevention programs that provide care coordination, health and parenting education, and home visiting for families with children. While some communities successfully coordinate these programs, there is no formal mechanism for coordinating the programs statewide. The Resource Mothers and the Baby Care Programs are discussed above. CHIP and Healthy Families

target families with young children. Virginia has no broad-based enabling services system for school aged youth. The Virginia Fatherhood Campaign, Teen Pregnancy Prevention Program, Abstinence Education Initiative, and Center for Injury and Violence Prevention support some community-specific services targeting this population. The 2000 General Assembly approved funding of $1.1 million per year in the upcoming biennium to implement the Virginia Right Choices for Youth Initiative. This initiative will focus on the positive healthy behaviors, positive assets, and right choices of youth and not on the negative risk behaviors. The five year goals include building the capacity of state, public, and private entities to work with regional, community/local entities to implement effective youth risk behavior prevention strategies, and increasing knowledge about the importance of parent and child connectedness, and school connectedness as protective factors for youth. So far, a statewide conference and five regional forums have been held. Plans also include the development of a partnership with one of the state four-year universities and the identification of other subcontractors who would provide assistance to communities in asset assessments, research and identify best practices and program models, disseminate information and develop additional resources.

The Comprehensive Health Investment Project of Virginia (CHIP of Virginia) receives an annual State appropriation of $2,142,544 (FY 01) to develop, expand, and operate a network of local public-private partnerships providing comprehensive care coordination, family support, and preventive medical and dental services to low-income, at-risk children. In 1999 CHIP of Virginia was supported by an additional $500,000 in grant funds. Local programs receive additional funds and in-kind support from local health departments, community action agencies, the Title V block grant, Family Resource and Support grant, and other sources. The CHIP network includes 11 community-based programs serving 29 localities. The programs serve approximately 2,300 families with 3,500 children aged 0-6 and 750 children aged 7-18 (CHIP of Virginia).

Healthy Families Virginia programs receive an annual State appropriation of $3,699,800 (FY 01) to provide assessment and referral for all new parents and voluntary, intensive home visiting services to high-risk families. In 1999 programs received over $1,000,000 from private foundations, plus support from multiple public and private sources. Local health departments provide staff for several programs.

The Healthy Families network includes 27 community-based programs serving 80 localities where nearly 85 percent of Virginia resident births occur. An additional 6 programs are under development. In 1998 over 3,000 new families were screened and 1,700 were enrolled for long-term home visiting. Prevent Child Abuse Virginia, a private nonprofit organization, provides site consultation and technical assistance.

Virginia's WIC Program provides nutrition education and supplemental foods for young children in families up to 185 percent FPL with nutritional need based on a medical/nutritional assessment. The WIC Program is administered by the OFHS Division of Chronic Disease Prevention/Nutrition, and funded by the Department of Agriculture. All local health departments provide WIC services and a total of 66,540 children were served in FY 98.

The Free Child Safety Seat Program is a statewide child safety seat distribution and education program for families with Medicaid eligible children administered by OFHS' Center for Injury and Violence Prevention (CIVP). Almost 7,000 seats are provided each year with funding from the state Child Restraint Special Device Fund. Most health districts provide local distribution.

In collaboration with the Virginia Department of Fire Programs, CIVP has initiated a smoke detector giveaway and education program in high-risk households in six areas. This program is funded by a three-year grant ($148,000 annually) from the federal Centers for Disease Control and Prevention (CDC).

Direct and Enabling: Services for Children with Special Health Care Needs

A 1999 needs assessment found that medical specialty capacity is excellent with a large number of high quality tertiary centers and pediatric specialty providers, if inconvenient to families in some parts of the state. Families participating in surveys and focus groups appreciated the breadth and quality of specialty services provided to their children in major medical centers, VDH Children's Specialty Services (CSS)

clinics, and physicians' offices. Most problems families encountered in using specialty care were related to the long travel distances to their children's care, the time it took to attend all their children's appointments, and scheduling difficulties. Southwest and Roanoke region families asserted more frequently that "needed services are not available in my community." *(Services for Children With Special Health Care Needs and Their Families, 1999)*

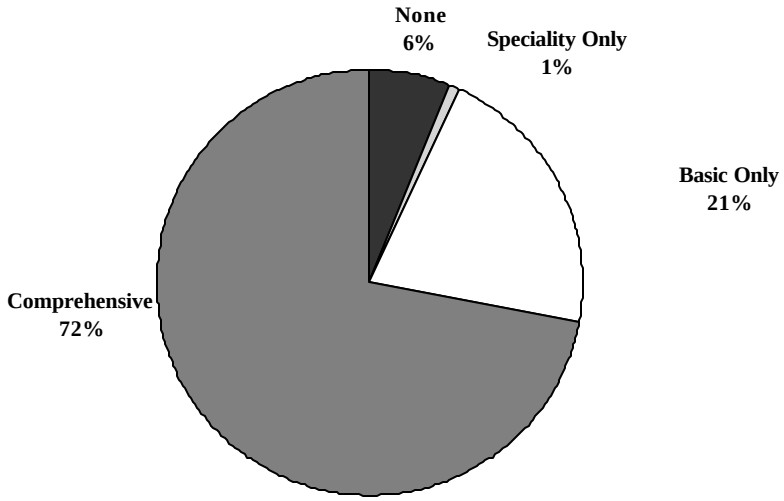
The Title V Children's Specialty Services (CSS) Program serves children in low income families from birth through age 20 who have congenital or acquired physical conditions specified by the Virginia Board of Health. CSS consists of following components: 1) statewide clinic services, 2) multi-disciplinary professional team services, 3) case management services, and 4) payment for hospitalization, physician clinic services, and ancillary services. Six regional medical centers having specialty clinics for comprehensive diagnosis, treatment, and surgery provide services. Field clinics are conducted in various settings with local health departments having the responsibility for case finding, initial eligibility determination, counseling and case management. In FY 99, 6,610 patients received CSS clinical services.

The Title V Child Development Clinics (CDC) provide a system for the early identification, diagnosis and treatment of developmentally delayed and/or disabled children from low-income families. Multi-disciplinary teams provide diagnostic and case management services to families and consultation to primary pediatric health care providers, schools, social services and other programs. CDCs provided services to 3,661 patients in FY 99.

Insurance coverage and benefits are not equitably and consistently available to all CSHCN families. Medicaid was found to be the most expansive insurance package available to children, while private plans often include limits and exclusions that prevent access to needed services for children. A 1999 population-based survey found 72 percent of CSHCN with comprehensive health insurance coverage, 21 percent with basic coverage, 1 percent with specialty coverage only, and 6 percent with no coverage (Chart 19) (Virginia Children's Health Access Survey, 1999). In a CSHCN sample survey, 35 percent of survey respondents disagreed with the statement that their insurance benefits were adequate. Families

with private or military coverage were much more likely to express dissatisfaction with their plans than families covered by Medicaid. Many families, particularly those with private insurance, reported experiencing financial hardship due to out-of-pocket costs for coinsurance, deductibles, and copayments (*Services for Children With Special Health Care Needs and Their Families, 1999)*

Chart 19: Insurance Coverage Among Children With Special Health Care Needs, Virginia 1999



Source Data: 1999 Virginia Children's Health Access Survey, Virginia Commonwealth University-Survey and Evaluation Research Laboratory

The CSHCN needs assessment found a large unmet need for support services for families with CSHCN. It appears that the current system does not possess adequate capacity to render family support services, including respite care, counseling, nutrition services, and transportation. Parents described the unremitting stress that accompanies caring for a child with a disability and the sense of isolation they often experience in parenting such children. Parents conveyed the belief that only other parents of CSHCN can fully understand them. While a small number of peer family support programs exist in Virginia, they are not well known to all CSHCN parents and unable to fully provide this critical service. The study recommended that VDH establish a statewide Family-to-Family Network that would provide social and emotional support and information to families of CSHCN in Virginia (*Services for Children With Special Health Care Needs and Their Families, 1999).*

Systems designed to serve families with CSHCN do not sufficiently and consistently value the experience and input of family members. While several positive examples of programs embracing a family-based philosophy were mentioned during the needs assessment, parents generally believe the system lacks a family-centered perspective. Parents reported that they sense a lack of respect from many providers concerning their knowledge of their children's medical issues, and a lack of understanding among providers about the stress parents experience in caring for their children. Nearly one-fourth of parents responding to the survey said they did not think family doctors, specialists, therapists, and mental health providers valued their input into decisions about their child's care (*Services for Children With Special Health Care Needs and Their Families, 1999).*

The combined results of focus groups, key informant interviews, and a parent survey revealed that systems of care for CSHCN in Virginia are not adequately coordinated and integrated. Despite the existence of strong case management services provided by CSS, local health departments, early intervention, and CHIP of Virginia, these programs do not reach all of the families who need these services. In fact, only 35 percent of survey respondents indicated that they had a case manager. Also, 27 percent of respondents did not believe that services for their child are well coordinated. As a result, families endure a large and unmanageable burden of coordinating care and navigating systems for their children (*Services for Children With Special Health Care Needs and Their Families, 1999).*

The mental health system lacks a necessary focus on children, and the public system appears especially weak for the most vulnerable children and their families. CSBs served approximately 24,000 children in FY 98—just 28 percent of the estimated children with serious emotional disturbance. Mental health system barriers and problems described by survey respondents and focus group participants included a lack of insurance coverage, inability to find a provider, long distances to providers' offices, and a lack of providers who understand children's issues. Due to insurance restrictions and financial limitations, families reported unmet needs for counseling services and medications for mental health problems (*Services for Children With Special Health Care Needs and Their Families, 1999).*

The *Code of Virginia* establishes the Part C System of Early Intervention Services of the IDEA in Virginia. It is designed to meet the developmental needs of children aged 0-3 who have a 25 percent developmental delay in one or more areas, atypical development, or handicapping condition. These services also address family needs related to enhancing the child's development. Described by families as a strong element of their children's care, the Part C/Early Intervention Program enjoyed a positive reputation among families who participated in the needs assessment. Early intervention served 5,023 children in 1998, representing an estimated 16 percent of CSHCN under age 3. Only a few families described problems using the services, which they attributed to issues of inadequate staff training, insurance coverage, and service availability (*Services for Children With Special Health Care Needs and Their Families, 1999).*

In contrast, the special education system was widely criticized by parents and key informants from the CSHCN study as having inadequate capacity, utilizing narrow interpretations of impairments that affect children's ability to learn, having insufficient numbers of special education teachers and nursing staff, and having poor linkages with the health care system, including VDH. Outside of schools, significant unmet needs were reported in the areas of speech therapy, physical therapy, and occupational therapy. (*Services for Children With Special Health Care Needs and Their Families, 1999)*

Four regional AIDS Resource and Consultation Centers address the special health care needs of persons with HIV through education of health care professionals on AIDS related issues. They offer clinical training for health care practitioners and students, medical consultation to community health care providers, and provision of current technical medical materials and literature. These centers are funded by a State appropriation of $1.2 million.

To provide medical care and essential support to individuals with HIV infection, Ryan White Title II funds ($ 2.1 million in 1998) are used to support five regional care consortia which assess client needs, identify service gaps, and provide needed services. In 1998, 2,317 eligible clients were served. Six percent of these were under age 19 (Division of HIV/STD, Virginia Department of Health).

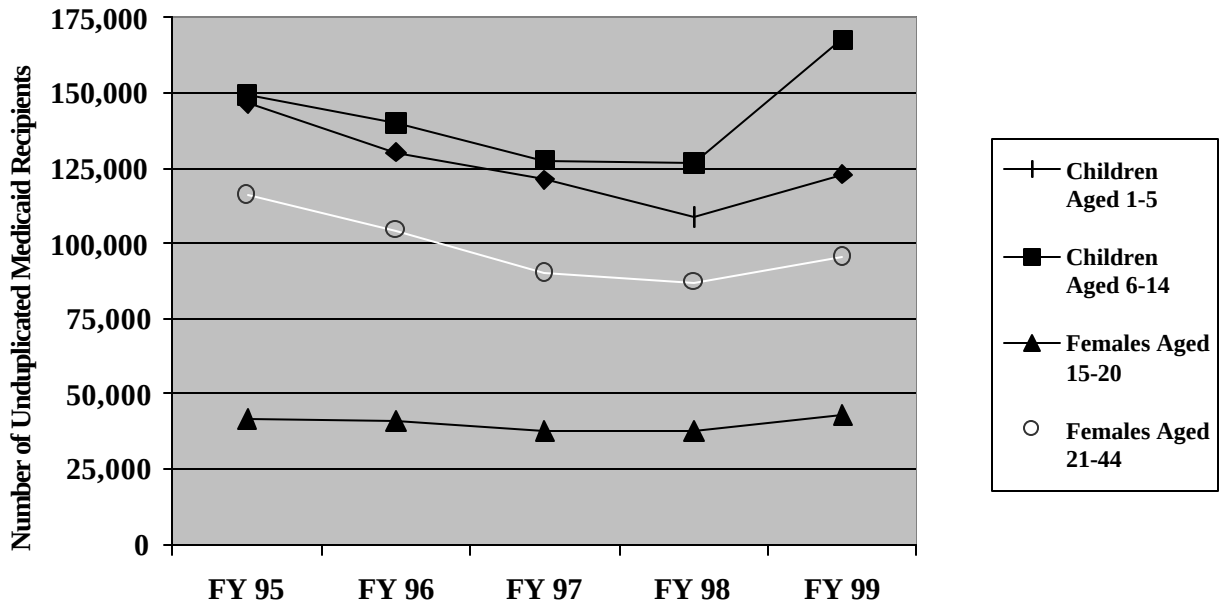
Regional Comprehensive Sickle Cell Centers, Genetic Centers, and Metabolic Treatment Programs also serve families of CSHCN. These are discussed further under Population-Based Services.

While the above resources are available to some, families are generally ill supported by the system as evidenced by a lack of information, advocacy, and support services. A major finding of the needs assessment was that both the families of CSHCN and the providers that serve them need access to a source of comprehensive, up-to-date information regarding available resources and programs, as well as effective referral and advocacy support to link families and providers to these resources. The study team recommended that VDH establish a statewide network of linked Regional Resource Centers for CSHCN to meet these needs.

Direct and Enabling: Services for All Title V Populations

Both welfare reform and the advent of Medicaid managed care have largely changed delivery, access, and utilization of both direct and enabling services for the entire MCH population. With the completion of Virginia's welfare reform, the state's Temporary Assistance to Needy Families (TANF) caseload fell 45 percent from 70,797 families in 1995 to 39,218 families in 1998. Following earlier periods of Medicaid expansions, large drops occurred in the numbers of Medicaid unduplicated recipients between FY 95 and FY 98. The heaviest declines were among eligible women aged 21-44 dropping 25.1 percent, and children aged 1-5 declining 25.7 percent (Chart 20, next page). In FY 99, numbers in these categories rose for the first time in four years to 95,579 and 123,113, respectively. While these remain well below FY 95 levels, the increases may be related to increased CMSIP outreach and efforts to enroll eligible former TANF recipients. Among females aged 15-20, drops were seen between FY 95 and FY 98 as well, but they rose by over 5,000 to a five-year high of 42,866 in FY 99 (Virginia Department of Medical Assistance Services). The percentage of all enrollees under TANF/AFDC categories continued falling to its lowest point in FY 99. Among all Virginia women aged 15-44, the proportion covered by Medicaid fell from 6.2 percent (1994-95) to 5.9 percent (1997-98) according to Census Bureau data published by AGI.

Chart 20: Number of Annual Unduplicated Medicaid Recipients, Virginia FY 95-99



Source Data: Virginia Department of Medical Assistance Services, Annual Report 1999

In Virginia, Medicaid benefits may be extended for up to one year following increased earnings or job program enrollment. National concerns, however, remain over the delinking of TANF and Medicaid with potentially Medicaid eligible persons losing coverage. Furthermore, a 1999 Joint Legislative Audit and Review Commission (JLARC) study found that 61 percent of former TANF recipients who had participated in Virginia Independence Program's (VIP) employment program were working, yet only 27 percent had jobs with health coverage. With the study cited average wage of $6.55/hour, purchasing health coverage may be cost prohibitive *(Virginia's Welfare Reform Initiative: Implementation and Participant Outcomes, 1999).* In Virginia, a parent working 17 hours weekly at minimum wage would have earnings too high to qualify for Medicaid for a family of three (Center on Policy and Budget Priorities).

These forces have impacted health department caseloads and resources. Between FY 95 and FY 97, the number of all health department Medicaid patients decreased 21.8 percent from 126,176 to 98,650 patients. Subsequently, DMAS payments to local health department clinics have fallen 45 percent from

9.6 million (FY 95) to 5.2 million (FY 99). Health departments have not offset these revenue losses. In addition, a higher proportion of patients (27 percent in FY 97) have become eligible for free services (at or below 100 percent FPL) (Office of Information Management, Virginia Department of Health). Local health department capacity and infrastructure has subsequently declined. This has contributed to staff losses and service restructuring in some districts.

Within Medicaid, delivery of services has grown more complex with the advent of managed care. Eighteen aid categories contribute to the eligible pool; however, most Virginia recipients eligible for managed care are in TANF, SSI, and CMSIP categories. For six years, DMAS has assigned Medicaid clients a primary care provider under the MEDALLION initiative covering 124 localities. Under federal law, family planning service requirements allow women to seek services from any qualified provider of choice, including local health departments, without prior referral. The first voluntary Health Maintenance Organization (HMO) enrollment program, Options, started in 1995.

Medallion II, DMAS' mandatory HMO program, was implemented in 7 Eastern Tidewater localities in 1996 and expanded to 6 additional communities the next year. In April 1999, Medallion II was expanded to 34 Central Virginia localities and will continue to be phased in statewide. Five HMOs are contracted with DMAS to serve Options and Medallion II clients. Under Medallion II, enrollees must choose an HMO within 60 days or one is assigned. Currently, 40.5 percent of all childbearing age women and 43.4 percent of all children aged 0-19 in Virginia reside within the 46 localities which have Medallion II.

Of all Medicaid recipients, 59.6 percent are currently enrolled in one of the three managed care plan designs and 30.5 percent are under Medallion II. In FY 99, 17,945 infants, 144,604 children aged 1-20, and 35,759 women aged 21-44 had either voluntary or mandatory HMO Medicaid coverage. Because of area demographics, MCH populations in capitated programs are more likely to be black (75.1 percent) than among all Medicaid program recipients (51.8 percent) (Virginia Department of Medical Assistance Services).

Managed care has brought greater availability of providers. DMAS reports 793 primary care providers in the region representing a 44 percent increase in primary care capacity. The number of obstetrician-gynecologists receiving Medicaid payments statewide doubled from 510 in 1988 to 1,035 in 1998. Most of this increase, however, occurred before the implementation of managed care. Increased reimbursements and network tie-in contracts requiring providers that participate in commercial plan networks to also participate in Medicaid networks as well have contributed greatly to the increase in Medicaid providers. The majority (59.1 percent) of 1998 Medicaid births was cared for by private physician (Virginia Center for Health Statistics). Access to facilities and providers, however, has become more dependent on participation in HMO networks.

With the shift to managed care, health departments have reduced their roles as primary and clinical providers as evidenced by greatly reduced or discontinued well child clinics, including EPSDT services. Between 1990 and 1998, a JLARC study found decreases in the number of local health departments offering sick child care (-31 percent), adult dental services (-30 percent), and indigent care for children and adolescents (-17 percent) (*Review of the Performance and Management of VDH, 2000)*. In Northern Virginia some pediatricians provide only episodic illness care to Medicaid recipients and refer them to the health department for well child care. In health districts where Medallion II originated, the number of Medicaid patients (all services) fell nearly 70 percent from 17,487 in FY 95 to 5,535 in FY 97. In the remaining health districts, Medicaid patients declined by 14.3 percent (Office of Information Management, Virginia Department of Health). These data likely reflect both the impact of managed care and of fewer overall Medicaid enrollees due to welfare reform and other economic forces.

Measuring services received by patients in Medicaid HMOs is incomplete at this time. DMAS is currently working with the HMOs to validate data submitted. Since unduplicated numbers of clients receiving categorical services in capitated plans are not available, it is difficult to assess care patterns completely.

While services and HMOs contracted vary by district, thirteen health districts have at least one Medicaid HMO contract. Four others are in negotiations. Nine districts provide obstetrical care services in these

arrangements and eight districts include case management in at least one HMO contract. Four of the districts provide well child clinical care and five provide dental care as a Medicaid HMO contracted provider. Family planning is the most common service contracted with 12 districts participating in at least one network (Health District Survey, Virginia Department of Health).

Although its clinical role has been reduced, many health departments still act as an entry point into care and a provider. Roughly one out of six (14.8 percent) of mothers aged 22 and older who gave birth in 1998 received a local health department maternal health service in FY 98 (Office of Information Management, Title V Data, Virginia Department of Health). Patients are screened for medical and psychological conditions, which determine a high-risk pregnancy and necessary referrals to perinatal centers for appropriate care. Helping high-risk mothers and teens obtain coordinated care has become an increased focus of the health department and its enabling programs such as Case Management/Baby Care and Resource Mothers. Ancillary services such as WIC and Resource Mothers have continued to experience increases in utilization despite managed care and shifting of clinical care sources. Concerns persist, however, over possible increased barriers due to multiple provider sites and transportation issues. While WIC caseloads have grown, the rate of growth is less than would be expected with the projected increases in its target population.

The shift to managed care has meant that while the number of local providers has increased, local health departments often do not know where to refer people. Determination of eligibility and assignment may delay prenatal care and other services up to 90 days as both social services and DMAS offices allow 45 days to process Medicaid applications. These concerns over delays in obtaining eligibility apply not only to pregnant women, but also to all maternal child health populations. Using new procedures and computer definitions, DMAS is working to reduce this time to 31 days by July 2000 in response to concerns.

DMAS requires all Medicaid HMOs to provide a "Baby Care-like" program or contract with a Baby Care provider. CMSIP regulations and DMAS' outreach for EPSDT have increased overall Baby Care caseloads statewide in all sectors. In managed care areas, most Medicaid HMOs have started providing

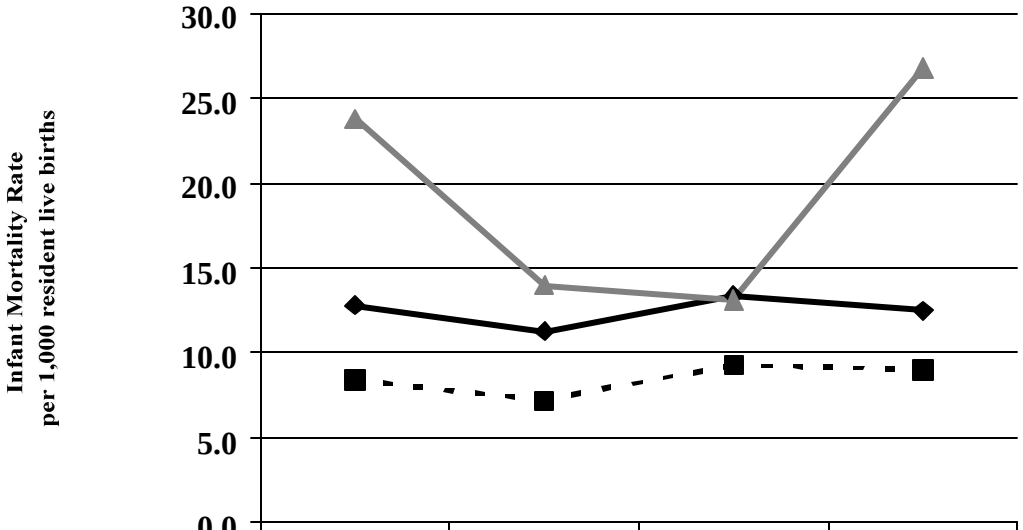
internal case management for patients with lower risks. Contracted health departments usually receive the highest risk referrals, which may be patients who are difficult to contact and have psychosocial problems, such as substance abuse. Maternal-infant case management at local health departments through Baby Care or no payment source fell from 12,971 (FY 95) to 8,712 (FY 99) (Office of Information Management, Virginia Department of Health). Health departments have lost revenues from the shifting of moderate and low risk patients, while maintaining a more labor intensive client base with increased mandated service hours at the same rate established eight years ago. Health departments have not obtained higher rates when entering HMO contracts. While $43 is provided monthly per case, service costs now reach $145 monthly based on a 1998 time study (Baby Care Program, Virginia Department of Health). In addition, more time must be spent on administration. Some health departments have reported difficulty in getting approval and reimbursement for services. Services, such as medical nutrition therapy for infants also need to be made reimbursable. DMAS is moving towards risk-based compensation to make reimbursements more equitable.

Case management outcomes have not been fully studied. One Medicaid HMO, which instituted a full scale program with nursing case management, in-home assessment, education classes, transportation, outreach workers, and incentives, has documented improvements. Preterm births (under 2,500 grams or less than 34 weeks gestation) decreased from 8.0 percent (1997) to 3.7 percent (1999). WIC enrollment has been increased among program participants from 15 percent to 98 percent (Virginia Chartered Health Plan). The level and skill in case management delivery, however, varies greatly by company. A common definition of case management has not been reached among public and private sector providers. The challenge remains for health departments and HMOs to define their roles and working relationships in assuring patients receive appropriate care and services.

Although Medallion II started in the perinatal region with the highest risks and poorest indicators, perinatal outcomes in the Hampton Roads HMO region have shown little change. The proportion of Medicaid clients with low weight births dropped slightly from 11.4 percent (1995) to 11.2 percent (1998) and very low weight births remained essentially unchanged at 2.5 percent. Between 1995 and 1998, the proportion of Medicaid clients with no prenatal care rose slightly (2.0 percent to 2.6 percent)

and with some fluctuations the percentage starting care early was slightly higher (65.9 percent versus 65.1 percent). Infant mortality rates also varied by year but remained at a level in 1998 (12.5) near 1995 (12.8) (Chart 21, next page). Numbers of infant deaths to mothers with Medicaid fell (Virginia Center for Health Statistics). Medicaid clients, however, consistently demonstrated worse outcomes and poorer utilization than those with private insurance. In one HMO, increases in first trimester prenatal care utilization over several years were seen in both Medicaid and traditional plan clients, however the 1998 difference between these clients remained significant at 68.4 percent versus 95.5 percent, respectively (Sentara Health Plan).

Chart 21: Infant Mortality by Payment Source,Hampton Roads HMO Region 95-98



	1995	1996	1997	1998
Medicaid	12.8	11.3	13.4	12.5
Private Insurance	8.4	7.2	9.3	9.0
Self Pay	23.8	14.0	13.1	26.8

Source Data: Virginia Center for Health Statistics

With the expansion of Medicaid eligibility, the advent of state children's health insurance, and the move to managed care delivery systems, the CSS service delivery system has become outmoded. This presents an opportunity for the Title V program to redistribute resources to assure access to quality care for all CSHCN, not just those who meet narrower categorical and financial eligibility requirements. The recent CSHCN Medicaid managed care waiver submitted highlights changing roles and collaborative opportunities. VDH is working with DMAS to link caseload information in order to identify CSHCN who are served by Medicaid and Title V. Once identified, Medicaid HMOs will be responsible for coordinating patient services and monitoring the access and follow-up of the services.

VDH continues to serve as a major safety net for the uninsured through its primary and preventive services that include prenatal, child health, and general primary care varying by individual health district. Several other organizations also work to provide care for those without a payment source. Virginia has 42 federally funded CHCs providing primary and preventive services for the maternal child health population as previously cited. In addition, 32 free clinics statewide provide medical care at no charge to the uninsured. In 1999, nearly 38,000 patients were served by Virginia free clinics (Virginia Association of Free Clinics). These clinics generally do not provide maternity or family planning services, but they do refer to local health departments. In five areas, free clinics and local health departments collaborate by sharing space. Both the CHCs and free clinics are placing a greater emphasis on outreach and lay health educators. This marks an opportunity where the Title V program could collaborate with these organizations which also care for the underserved.

Academic Health Centers at major universities across Virginia provide a substantial portion of care to indigent and underserved persons. The Title V program has numerous relationships with these health centers, which serve MCH populations, through program based efforts such as the Genetics Centers,

infrastructure building initiatives such as the RPCs, and evaluation-focused relationships for numerous population-based programs such as the Teen Pregnancy Prevention Initiative (TPPI).

Other foundations also support projects addressing needs of the underserved. Established in 1992 to promote public-private partnerships, the Virginia Health Care Foundation (VHCF) funds community-based projects to increase primary care providers in underserved areas through a $2.2 million state allocation and private donations. Through the conversion of Trigon Blue Cross/Blue Shield and eight community hospitals to for-profit status over $500 million has been put into health related foundations. While the Title V program has no formal relationships with these foundations, various local health districts have received some grant funding for community-based maternal and child health projects.

As traditional minorities and immigrant, refugee, and migrant worker populations continue growing, cultural competency has become a prominent issue identified by both consumers and providers. In Virginia, one out of five citizens is black. The state ranks as the 9th largest for immigrant residents and 8th among intended residence for new arrivals (Weldon Cooper Center for Public Service, University of Virginia). Growing inhabitants have placed Virginia as having the 16th largest Hispanic population and 9th largest Asian population in the country (U.S. Census Bureau). Racial and ethnic disparities in health outcomes highlight the importance of providing effective direct and enabling health services for Virginia's increasingly diverse maternal and child health population. VDH's MultiCultural Health Task Force (MCHTF) has conducted a multi-wave statewide research initiative by surveying VDH CSS and CDCs (1998), Dental Clinics and Programs (1999) and all local health districts (2000) and Primary Health Care's community health centers. In addition, 16 multicultural focus groups across the state were conducted this past year.

Throughout each wave, language was the most frequently cited barrier by service providers. All health districts, except two, indicated they had some access to translation services available, which were usually in Spanish. These resources, however, are not available in sufficient numbers, various languages, or on an "as needed" basis. Less than half (39 percent) of survey respondents in the health district survey indicated that they "always" or "usually" had access to help for working with non-English

speaking persons. Although the majority (70 percent) indicated they "usually" had access to language appropriate materials, needs for a wider range of appropriately translated materials, a central repository for translated materials, an interpreter registry, and avoiding duplication of translation efforts were identified (*Cultural Competency in Public Health: Meeting the Needs of Virginia's Multicultural Populations, 2000)*.

Other barriers identified by providers included socioeconomic barriers such as poverty, mistrust (this may vary based on the alien status), illiteracy in native language, transportation, and lack of insurance (*Cultural Competency in Public Health: Meeting the Needs of Virginia's Multicultural Populations, 2000)*. Some multicultural groups mistrust government institutions due to previous political history in their country of origin or fear of deportation or abuse. Transportation needs were most acute in the rural parts of the state. The CHSCN providers also cited lack of program awareness as an impediment to utilization by multicultural populations.

Lack of personnel, funding, cultural training, and flexible hours arose as other systems-based issues, which presented barriers to care. Nearly half (46 percent) of all health district respondents indicated that they "never" stationed outreach workers in high-density multicultural communities. Outreach conducted "usually" was through churches and other places of worship (39 percent), traditional and alternative health providers (42 percent), and welfare, employment, child welfare, and juvenile justice agencies (45 percent). Lack of funding was identified as a major obstacle for hiring interpreters and bilingual staff, conducting outreach activities, translating materials, and providing staff training (*Cultural Competency in Public Health: Meeting the Needs of Virginia's Multicultural Populations, 2000)*.

Through focus group discussion, preliminary results show that frustration, disappointment, and limited communication were the most frequent problems cited by the target population. Many had unfulfilled or unrealistic expectations of the U.S. health care system and for those who previously had universal health care coverage, the transition was difficult. Participants also highlighted the inability to navigate complex systems of health care and insurance coverage requirements, particularly those requiring referrals, pre-admissions, and partial procedural reimbursements. Many perceived emergency rooms as the easiest

way to obtain care. Additional barriers named largely matched those identified from providers and included lack of insurance and/or money, transportation, language, and access to interpreters. Lack of understanding cultural differences in religious practices, approach to medicine, family decision making authority, and male/female gender interaction complexities resulted in consumers' perceiving unacceptable or offensive behaviors by providers. Needs for systems based improvements to increase service delivery in understandable, acceptable, and appropriate ways became evident in the research.

Understanding practices and beliefs from the country of origin or ethnic group emerged as a critical piece to providing effective services. The need for CSHCN providers to understand the impact of diverse beliefs regarding chronic disease and disability is imperative as many come from systems where these conditions carry great stigma and are not treated for various reasons. In addition, many CSHCN and their parents have been subjected to a variety of intolerable social conditions in their former countries of origin, such as war and violence, which contribute to long term chronic conditions and developmental disabilities (*Cultural Competency in Public Health: Virginia's Response to Children with Special Health Care Needs, 1998).* Dental health may not be perceived as an important factor in overall health in many countries of origin *(Cultural Competency in Public Health: Virginia's Response to Dental Trends and Issues among Multicultural Populations, 1999)*. Delivering acceptable women's health services also must encompass an understanding of traditional decision-making hierarchies and male-female gender complexities, as many patients may originate from areas where violence against women is accepted or women's decision making ability is limited.

Knowledge remains, however, an area where most providers have "some' or 'a little'. In knowledge of historical and cultural information, respondents were most likely to say they knew "a lot" about blacks or African-Americans. Regarding provider knowledge of social, economic, and health concerns, "some" knowledge was the most frequent response for blacks or African-Americans (50 percent) and white Hispanics (72 percent). Respondents were also most likely to say they had "some" knowledge of Mexicans (60 percent), Asian-Pacific Islanders (59 percent), and Middle Easterners (50 percent). While the importance of education was identified, 35 percent stated their agency "never" provided training in cultural awareness or competency issues and 48 percent indicated training was done on an

"other" basis. In addition, while the majority of agencies (90 percent) collected culture specific information, most reported having only informal policies for use of culture specific assessments for diagnosis and treatment (50 percent) and use of culture-specific treatment approaches (52 percent) (*Cultural Competency in Public Health: Meeting the Needs of Virginia's Multicultural Populations, 2000)*.

Health departments surveyed did perceive that once multicultural populations overcame initial concerns of mistrust or stigma associated with "welfare" services, that they had positive perceptions of the services received. In addition, health departments were seen as a valuable starting point from which to enlist the aid of other social service organizations and community resources.

Recommendations made by the MCHTF encompass strengthening the infrastructure needed to adequately serve multicultural populations through developing community linkages; identifying or providing training opportunities; developing resource lists and possibly a centralized resource center for translated materials; creating and instituting formal policies geared for multicultural populations; and planning, designing, and evaluating programs which utilize a cultural assessment (*Cultural Competency in Public Health: Meeting the Needs of Virginia's Multicultural Populations, 2000)*.

The 1999 CSHCN needs assessment produced inconclusive and sometimes conflicting evidence regarding the ability to deliver culturally competent services. Survey responses about system satisfaction did not vary by ethnic group; however, when asked if doctors, mental health, and support services providers were sensitive to their cultural and language needs, more than half of parents said "no." Key informants believe the current system is ill equipped to meet the needs of increasing Hispanic families in Northern Virginia (*Services for Children With Special Health Care Needs and Their Families, 1999)*.

Cultural competency extends beyond language capability and includes acceptability of care. VDH contracted with VHSI partners Virginia State University (VSU) and Norfolk State University (NSU) to conduct focus groups with low-income African-American citizens in Norfolk, Portsmouth, and

Petersburg housing developments to explore their views of infant mortality, low birth weight babies, and prenatal care.

While the majority of respondents expressed basic knowledge of prenatal care importance and where to get services, other access issues emerged. Participants related concerns about obtaining transportation, ability to pay, health care support services, long waits at facilities, reduced neighborhood based services, and negotiating the health care system. The ability to speak with a health care provider at convenient times and having adequate time with the provider were problems cited. Respectful, caring, and nonjudgmental treatment by providers was an unmet need as many felt that quality of care and provider attitudes were linked to insurance type. Dental care, eye care, and mental health were named as needed services often not covered by insurance plans.

Respondents identified substance abuse, denial of pregnancy, especially among teen mothers, and involvement in a physically abusive relationship as factors that delay entry into prenatal care. Women spoke about fear of testing positive which might lead to involuntary treatment, legal issues, or custody problems. Consumers suggested involving males and other family support persons and using community-based efforts to help increase prenatal care usage. Increasing cultural competency will continue to be a focus of future efforts for VDH services as well as development of infrastructure statewide among all sectors to meet this growing need.

3.1.2.4 Population-Based Services

Title V serves various population-based cohorts among women, infants, children and CSHCN. Several of these programs have multiple funding streams. Some of the programs discussed are not Title V funded but are included to help complete the picture of services available statewide. Many of the population-based programs managed by the state operate through community-based coalitions and organizations. Title V coordinates with universities to evaluate several of these programs. Some CSHCN services, such as Metabolic Treatment and Genetics Centers, are contracted largely through university based health centers. Other collaborative efforts include working with state level professional organizations, such as

the Medical Society of Virginia, involving both the private and public sectors. Mandated programs, such as immunizations, are available statewide. Other programs more reliant on community-based organizations, such as teen pregnancy prevention, are often in targeted areas or in areas selected through competitive application processes. In the past five years, many family strengthening programs, such as the Virginia Fatherhood Campaign, have been initiated or expanded.

Population-Based: Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants

The Virginia SIDS Program is a statewide referral and notification system for ensuring that families affected by SIDS receive a family contact within two weeks of the infant's death. In 1996, the Division of Women's and Infants' Health (DWIH) restructured follow up for these families following recommendations from a multidisciplinary team including the Office of the Chief Medical Examiner's (OCME), local public health nurses, and Virginia SIDS Alliance representatives. Initiated by the Medical Examiner's (MEs) office, referrals are carried out by regional public health nurse coordinators. Involvement of families is only at their request and they are provided referrals and education about SIDS. Of the 82 SIDS death cases in 1998, 56 (68.3 percent) referrals for family bereavement support were made from the MEs office. Referrals were made within two weeks in 64.3 percent of the time. Successful contacts were made in 51 (91.1 percent) cases. The Virginia SIDS Alliance at the local level provides a major link to the other community resources on assisting families dealing with the tragedy of losing their child. Prior to 1997, the Virginia SIDS Alliance in partnership with VDH had sponsored an annual training for both professionals and families on issues regarding SIDS. Due to lack of funding, this training has not occurred in two years.

The Partners in Prevention (PIP) initiative, funded with TANF funds ($ 1,000,000 in FY 00) and managed by DWIH, is dedicated to reducing nonmarital births. PIP collaborates with the Virginia Fatherhood Campaign and the Virginia Abstinence Education Initiative. Together, these initiatives seek to

strengthen families by promoting healthy, responsible relationships between couples and the benefits of an active two-parent family to children. PIP supports 17 community-based coalitions covering 48 Virginia localities. PIP coalitions educate, mentor, and counsel young adults and teens on the benefits of waiting until marriage to conceive a child. Since 55.5 percent of 1998 nonmarital births occurred to females aged 20-29, young adults are the primary target. This represents a new focus for many community-based prevention programs, which have previously targeted teens exclusively.

VDH in cooperation with the Medical Society of Virginia has been requested to aggressively seek to reduce the incidence of osteoporosis among citizens of the Commonwealth. Funds are needed for a program coordinator and to purchase education materials. School based education about osteoporosis and its prevention is a continuing need in Virginia. VDH currently collaborates with the DOE on projects for osteoporosis prevention but information needs to be incorporated in the state Standards of Learning (SOLs). Title V staff serve on the Virginia Osteoporosis Coalition which helps educate teachers, parents and students about the disease and how lifestyle choices, nutrition and physical activity can help prevent the disease in adults.

The Virginia Breast and Cervical Cancer Early Detection Program (BCCEDP), Every Woman's Life, utilizes $1.6 million in federal Centers for Disease Control and Prevention (CDC) funds to provide public awareness, screening, case management, professional education, and quality assurance for the early detection of these cancers. With BCCEDP targeting women aged 50-65, unmet needs persist for under served and uninsured 35-49 year olds.

Population-Based: Preventive and Primary Care Services for Children

A *Code of Virginia* mandated service, immunizations are provided by all local health departments. VDH's Division of Immunization within the Office of Epidemiology has primary responsibility for this service. The division provides federal CDC funds to each health district for infrastructure enhancement of the vaccine delivery system. The CDC funded Vaccine for Children program provides vaccine at no cost for children who are Medicaid enrolled, Native American, or uninsured through local health departments

and enrolled private physicians' offices. The Title V program supports immunizations by promoting quality primary care services through a medical/health home. With 80 percent of two-year olds fully immunized, Virginia has not yet met the Healthy People 2000 objective of 90 percent.

A statewide household survey found that having multiple immunization providers is the norm. A private provider is the usual source of immunization for 80 percent of children. Central and Eastern Virginia have significantly more under-immunization than Northern or Western regions. Medicaid, CHAMPUS, and non-insured populations have lower rates than the privately insured. Only one-third of parents recall having been reminded about immunizations (Virginia Child Health and Immunization Survey, 1998).

In addition to consultation and training for Head Start and child care providers, Title V program staff serve on coalitions to promote good nutrition such as the Virginia Osteoporosis Coalition previously discussed. The Virginia Coalition for National Nutrition Month sends educational materials to teachers each year during March.

Infrastructure is in place for statewide childhood lead poisoning screening and intervention, but further work is needed to refine the reporting system, to raise public awareness of lead-safe practices, to raise physician awareness of the need for screening, and to develop a tracking methodology for all homes made lead safe. While the *Code of Virginia* requires reporting of child blood lead levels greater than 10 μg/dL to VDH, all laboratories have voluntarily agreed to report all blood lead test results. Only one-fourth of young children are currently tested for lead poisoning. In a statewide survey, 65 percent of respondents with children under age 6 said their health care provider had never talked to them about childhood lead poisoning. Virginia has no tracking mechanism in place to measure the progress of home remediations outside of grant-funded projects. VDH is addressing these gaps with $750,000 from the federal CDC Childhood Lead Poisoning Prevention Program and $500,106 from the EPA State Lead Program.

Fluoridated water is provided to 81 percent customers served by community water systems, meeting the Healthy People 2000 objective. Base funding of $40,000 from the Preventive Health and Human

Services (PHHS) Block Grant is insufficient to meet the need for initiations and upgrades of community water systems in Virginia. These needs will be only partially met in FY 00 through a Water Fluoridation Systems Development grant from CDC and Title V funds. The Division of Dental Health monitors all fluoridated water systems in partnership with the VDH Office of Water Programs and the State Division of Consolidated Laboratory Services.

A Healthy Child Care Virginia needs assessment examined concerns regarding child care facilities' health and safety environments. Facilities identified infectious diseases as the top health priority of child care providers, followed by falls. Only 25 percent reported that children were required to wear safety helmets when riding tricycles or wagons. Most facilities rely on VDH and DSS for health and safety resources. Title V program staff conduct training sessions for child care providers on nutrition and safety, disseminate safety information to families, and serve on the Head Start Health Committee and the Healthy Child Care Virginia project advisory board.

VDH's CIVP promotes child safety through public information, training and community education, community events, and coalitions. Unintentional injury programs focus on home, recreation, and transportation safety and target child care providers, schools, and health care providers. The Center distributes materials through its resource center, provides program consultation and technical assistance, and serves as the consumer product safety liaison for Virginia. Many childhood injury prevention services are provided through broad-based coalitions. The Virginia SAFE Playgrounds Committee raises awareness about playground safety in day care facilities, schools, parks and recreation departments, communities and people's backyards through disseminating educational materials and presentations. The Virginia Water Safety Coalition is dedicated to helping youth and their parents be safe when they are in, on or around the water through distributing educational materials and maintaining a website.

The CIVP is collaborating with schools in 18 localities to implement *Risk Watch*, a broad-based injury prevention curriculum that targets the eight major risk areas that kill or injure the most children aged 14 and younger: motor vehicle crashes; fires and burns; choking, suffocation and strangulation; poisoning; falls; unintentional firearms incidents; bike and pedestrian hazards; and water hazards.

The CIVP's Child Transportation Safety Program provides consultation and coordinates statewide multi-media information campaigns on child transportation safety issues such as motor vehicle passenger and bike safety. Staff develop education materials on child restraints and seat belt use and provide training throughout Virginia on the use and installation of child safety seats. This initiative is supported by a highway safety grant. The Piedmont Region Child Fatality Review Team has identified the need for alcohol and car safety strategies targeting adolescents.

An assessment of Virginia's sexual assault prevention services identified a need for education of school age children and adolescents in sexual assault prevention. The study suggested that such programming could be school-based and/or offered through organizations working with youth. The VDH CIVP is addressing these needs with PHHS Block Grant funds from the Violence Against Women Act.

A 1999 Virginia Youth Violence Needs Assessment identified the need for coordination of multiple community level efforts, increased access to timely and relevant information for agencies, improved training and supervision for existing prevention program workers, and evaluation of efforts to help reduce youth violence. Program needs identified were in the areas of mentoring, bullying reduction, character education and conflict resolution, after-school supervision, juvenile offender assistance, and public awareness. The report emphasized public health's role in reducing youth violence through providing assessment, assurance, and policy evaluation and recommendations (*Youth Violence Prevention in Virginia: A Needs Assessment, 1999).*

Although various groups in different Virginia localities seek to prevent suicide, there is limited coordination and collaboration among programs. These programs implement a variety of grass roots approaches to suicide prevention with minimal resources. Most CSBs do provide some type of prevention education, after-school, and/or mentoring programs that includes information about suicide prevention. However, very few CSBs are providing specific programming targeting this area. The 1999 "Report to the General Assembly on Suicide" highlighted the need to allocate suicide prevention

resources for planning, training, local project funding, research, and public awareness. The 2000-2002 State budget newly allocates $75,000 to VDH for suicide prevention initiatives.

Teens Against Tobacco Use (TATU), a project of the VDH Tobacco Use Control Programs (TUCP), trains middle/high school youth to teach elementary school children about tobacco. In addition TUCP uses many strategies to involve youth in developing and promoting tobacco control policies. VDH is working with the DOE to implement the CDC endorsed TATU, Project TNT (Towards No Tobacco Use) and Life Skills Training (LST) tobacco prevention and classroom curricula for middle school students. CDC's Comprehensive State-Based Tobacco Use Prevention and Control Program fund these services.

To promote responsible sexual behavior, the Virginia Abstinence Education Initiative includes six abstinence until marriage model programs to reduce teenage sexual activity, sexually transmitted diseases, and pregnancies. The initiative utilizes media to provide an abstinence until marriage message to counter other prevalent sexual messages. A longitudinal, quasi-experimental program evaluation design is in place for tracking youth sexual behaviors and fertility and to measure program effectiveness. With VDH's Office of Health Policy as the lead agency, an evaluation consortium composed of university representatives is supervising evaluation efforts. Training in reinforcing the abstinence message is given to youth serving agencies. Priority needs are being met with the Title V Abstinence Education grant of $828,619, plus an additional $121,000 from TANF funds (FY 00).

The State Appropriations Act provides $1,400,000 per year in Medicaid program funds for Teen Pregnancy Prevention Initiatives (TPPI) in the Richmond, Norfolk, Alexandria, Roanoke City, Crater, Portsmouth, and Eastern Shore health districts. These sites were mandated due to historically high teenage pregnancy rates. VDH is directed to evaluate these programs to ensure that the prevention methodologies are successful and transferable to other areas. TPPI sites provide a variety of site-specific programs which were determined through community needs assessments and in conjunction with a local teen pregnancy prevention coalition. VDH contracts with Virginia Commonwealth University (VCU)-

Survey and Evaluation Research Laboratory (SERL) for the evaluation component, which includes qualitative and quantitative data regarding program outcomes.

The Virginia Fatherhood Campaign (VFC) promotes programs and policies that support father-presence in the lives of their children and improve the quality of fathering. The campaign consists of a resource center; statewide media campaigns; consultation, technical assistance, and training for local and state programs; and seed grants to support community projects. In FY 00 seed grants were awarded for 12 programs covering 32 localities, however demand exceeds available funds. The campaign is supported by Title V funds and $300,000 from TANF (FY 00).

DSS provides leadership for the prevention of child abuse and neglect. Using state and multiple federal grant programs, DSS contracts with community organizations to provide a variety of prevention services (including some home visiting and case management services described under Enabling Services) targeting the general population and families at high-risk for child abuse and neglect. Prevent Child Abuse Virginia provides technical assistance for parenting education programs and for Parents Anonymous groups. A DSS community needs assessment has identified unmet needs for parent education, child care, and other services to support families.

Population-Based: Services for Children with Special Health Care Needs

To reduce unnecessary morbidity and mortality from potential or existing genetic conditions, the *Code of Virginia* requires genetic screening of all newborns for biotinidase deficiency, phenylketonuria (PKU), hypothyroidism, homocystinuria, galactosemia, and Maple Syrup Urine Disease, and sickle cell diseases. In 1998, 96,224 infants were screened. As part of the Newborn Screening Program, VDH notifies the attending physician of any suspicious results. Further diagnostic testing, if required, is performed at a laboratory of choice as the state laboratory has only screening capability. In 2000, SB 699 directs the Commissioner of Health to examine issues, costs, and benefits of testing newborns for congenital adrenal hyperplasia (CAH) and make recommendations. A fee-for-service program, the Newborn Screening

Program is supported by newborn screening fees through the Department of General Services, Division of Consolidated Laboratory Services.

Genetics screening/testing, education, counseling and follow-up services are provided through four regional centers located in Charlottesville at the University of Virginia (UVA), Richmond at Medical College of Virginia (MCV), Fairfax at Genetics and IVF Institute, and in Norfolk at Eastern Virginia Medical School (EVMS) and 11 satellite clinics. Contracts with UVA and MCV support metabolic treatment services for indigent families as well. Title V funding assures service availability for all Virginia residents and serves to remove financial barriers for the medically indigent. Access to service, however, continues to be a problem. There is a need for an enhanced understanding of insurers and public and private providers that genetics is an integral part of both health promotion and disease prevention.

In addition to the current provision of medical formulas needed to treat children with PKU in medically indigent families at a cost not exceeding 2 percent of their annual income, Virginia HB 542 this year mandated reimbursement for special low protein modified foods as well. VDH will be responsible for up to $2,000 annually per diagnosed person, including pregnant women and children. Currently 67 Virginia children up to age 21 are identified with PKU by VDH (Division of Women's and Infants' Health, Virginia Department of Health).

The *Code of Virginia* mandates VDH, in conjunction with local health directors, to establish a voluntary program for screening individuals for sickle cell disease or trait. Enhancing sickle cell trait identification, VDH's Adult Sickle Cell Program screens family planning and maternity patients and their partners. Local health departments provide sickle cell education, screening, and counseling under Title V funding for these groups.

Five regional Comprehensive Sickle Cell Centers provide comprehensive services for those affected by sickle cell with treatment, follow up, physician consultation, family and client education, case management, and other services aimed at assisting families. These centers are funded by allocated state funds of $250,000 for the provision of sickle cell services. The VDH Title V program along with the

Virginia Sickle Cell Awareness Program (VASCAP) provides oversight of these centers. VASCAP supports VDH in the provision of screening and education services. With a combination of funding sources including Title V, VASCAP provides education to schools, organizations, and other groups, conducts outreach, and promotes general awareness.

The *Code of Virginia* in 1985 established the Virginia Congenital Anomalies Reporting and Education System (VaCARES), a statewide birth defects registry. VaCARES collects data to evaluate possible causes and seeks to improve diagnosis and treatment of congenital anomalies. The program also informs parents and physicians about available resources. As part of a "passive" system, Virginia hospitals submit reports on children from birth to age 2 who have at least one diagnosis from a specified ICD-9 code list of anomalies. Identified families receive general VaCARES information, including a toll-free phone number. Needs for this program focus on timely analysis and reporting of data. An aggregate report for 1991-95 will be completed this year. Data are needed to better identify service needs and guide future program planning for Virginia's children with special health needs. The feasibility of conducting a comprehensive needs assessment addressing overall genetics information, service gaps, family and client issues, and existing resources is being examined. MCV will lead the process with support and guidance from the VDH Genetics Program. VaCARES is funded by the Title V program.

The *Code of Virginia* requires that, beginning July 1, 2000, all infants born in a hospital having a newborn nursery or other birthing center be given a hearing screening before discharge. The *Code* gives VDH responsibility for identifying and monitoring infants with hearing impairment to ensure that such infants receive appropriate early intervention through treatment, therapy, training, and education. Through the Virginia Hearing Impairment Identification and Monitoring System (VAHIIMS), a state level advisory committee, hospital screening program, and data system are in place for all newborns to receive screening and follow-up for hearing loss. Further program development is needed on linking screening with follow-up care, linkage with other newborn screening programs, professional and public education, and program evaluation. The proportion of newborns screened for hearing loss increased from 2 percent in 1997 to 60 percent in the last half of 1999. VAHIIMS is funded by the Title V Program.

No systematic, statewide mechanism exists to identify all CSHCN. While some programs in place, such as the Newborn Screening Program, VAHIIMS, and VaCARES, help determine children with special needs, these systems are not adequate to recognize all children with conditions and illnesses that limit their ability to function. The need remains for these databases to be completely integrated within VDH as well.

3.1.2.5 Infrastructure Building Services

Strengthening infrastructure constitutes an increasing focus of VDH and its Title V programs in the past five years particularly with the changing emphasis from clinical to assessment and assurance functions. To promote comprehensive systems of services, VDH has participated in or taken the lead in numerous and augmented interdisciplinary efforts bringing together both the public and private sectors. Movement continues in this direction through collaborative efforts involving all maternal and child health populations. Cooperative efforts with agencies such as DMAS and DSS have grown due to shared target audiences such as TANF and Medicaid managed care populations. Currently, VDH is focusing on infrastructure needs related to strengthening families, improving identification of at-risk populations, reducing racial and ethnic disparities, delivering services to CSHCN, and assuring access to quality care with special attention to the managed care environment.

To more equitably address local needs, the OFHS has revamped its Title V funds distribution formula to local health departments. Eventually complete local allocations will be based on poverty births versus historical patterns. In addition, VDH has begun requiring performance measures with Title V funding to increase accountability. The need exists to further develop these measures which will be addressed in the future through consultant-based training. VDH has worked to build program evaluation into state and local initiatives through numerous formal university-based contracts and requirements in written agreements with local and state service contractors. Health policy assessment, evaluation, and assurance roles have been expanded through newly created positions addressing managed care and newly passed legislation mandating VDH's role in this area. Assessment functions have been strengthened by building collaborative arrangements, such as Title V access to the statewide hospitalization database maintained

by Virginia Health Information. Completing at-risk populations database linkages, obtaining PRAMS-like survey data to better assess concerns such as perinatal substance abuse and domestic violence, and acquiring survey data on current youth health behavior patterns are unmet needs. These data will enhance VDH's ability to perform assessment functions.

Infrastructure: Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants

Regional Perinatal Councils (RPCs) work toward improving and promoting perinatal health in Virginia. A 1996 assessment by VCU found that there has been effective work throughout the state to reduce infant mortality. To promote building of local infrastructure, each region has maintained a regional perinatal council, developed structure and bylaws, and formed working committees. Through a VHSI funded technical assistance contract, the Center for Pediatric Research (CPR) at EVMS has recently assisted RPCs to increase consumer and minority participation. RPCs assess educational needs and deliver appropriate educational services to perinatal health care professionals. All regions conduct at least one Fetal and Infant Mortality Review (FIMR) program at the community level. Several regions have ongoing maternal transport reviews. Since the creation of the RPCs, which were based upon two academic-based perinatal centers, other perinatal centers providing high-risk care have emerged in the urban areas of Regions 5, 6, and 7. The care of high-risk neonates continues to become more diffused among both public and private caregivers.

To improve quality and availability of care for women and their infants, particularly those who are poor, live in underserved areas, and are at risk of infant death and disabilities, the Virginia Chapter of the American College of Nurse Midwives (ACNM), and VDH's DWIH have initiated work to improve collaborative practices in the state. Under a grant from the ACNM and the MCH Bureau, provider organizations have been brought together to start dialogues about how stakeholders can work together to share care and maximize resources. Joining the initial meeting were the Virginia Chapter of the ACNM, the Virginia Council of Nurse Practitioners of the Virginia Nurses Association, the Virginia Academy of Family Physicians, the Virginia Society of Obstetricians and Gynecologists, the Virginia

Chapter of the American Academy of Pediatrics, Shenandoah University's Graduate Nurse Midwifery Program, and the Center for Primary Care Resource Development. This group is working to educate providers about the myths and realities of collaborative practice and teach them how they can create or expand shared care into current practice for the benefit of their patients. VDH has plans with the Virginia Chapter of ACNM to continue facilitating these cooperative efforts. This type of collaboration was recommended in several legislative studies.

The Virginia Council on Folic Acid was established in 1999 to meet education gaps regarding folic acid education to prevent birth defects. They have recently conducted a statewide campaign promoting folic acid consumption. Organizations collaborating with VDH as members of this Council include: the Virginia Pediatric Society, the Virginia Perinatal Association, the Medical Society of Virginia, the Virginia Nurses Association, Women's Missionary Union of Virginia, Virginia Cooperative Extension Service, Virginia Commonwealth University, March of Dimes Birth Defects Foundation, Health Management Corporation, James Madison University, the Virginia Dietetic Association, the Regional Perinatal Councils, Spina Bifida Program at the Children's Hospital, the Virginia Pharmacists Association and the Virginia Association of Family & Consumer Sciences. Based on unmet needs, the Council plans to publicize resources available through establishing a Resource Center and maintaining a web site. Education efforts include investigating effective ways to educate at professional meetings/conferences and adding folic acid education in state nursing, medical school, and master of public health program curriculums as well as the state SOLs. They also are addressing lack of access to vitamins by low-income women. The Council is working to identify standards of practice, legislative issues, and evaluation needs, as well as participating in the revision of FIMR's interview questionnaire to add folic acid questions.

The Virginia Breastfeeding Task Force (VBTF) works to increase the incidence and duration of breastfeeding among mothers and to provide a statewide organizational vehicle for communication, collaboration, and coordination of breastfeeding services. VBTF assesses breastfeeding support of Virginia hospitals and offers educational services to mothers and professionals. With VDH as the lead agency, the Task Force is made up of executive officers and is in active recruitment for a Professional

Advisory Board. Currently, the majority of task force members are from the health care industry. Mothers also serve on the group as well. One goal is to gain wider representation from other areas such as public education, workplace, insurance, day care centers, and research to meet the National Health Objective for breastfeeding more quickly. Current breastfeeding data collected on newborn screening forms do not report exclusive breastfeeding nor credit mothers giving bottled breast milk. A great need exists to develop a system to collect accurate and comparable breastfeeding data from Virginia hospitals.

VBTF has embarked on several infrastructure building activities to promote breastfeeding. To assess existing systems and collaborative mechanisms for primary and preventive services for women, VBTF created a liaison position to open communication between the 12 local task forces and the State Task Force. A recent survey of 175 businesses found that the majority believes breastfeeding saves money in health care costs and over half provide a private place for employees to pump or nurse. To increase medical community knowledge and support, VBTF has supported curriculum development such as the Basic Breastfeeding Curriculum, which targets standards of care for hospital personnel. In addition, the Virginia American Academy of Pediatrics breastfeeding coordinator is developing a curriculum to be implemented for the EVMS pediatric resident program. Addressing a need to institutionalize promotion of breastfeeding, VBTF requested the National Committee for Quality Assurance, the Joint Commission on Hospital Accreditation, and the Department of Health and Human Services to include lactation services in their performance measures.

Three Baby Care Regional Councils meet semiannually to promote a comprehensive service system and address issues affecting mothers and infants with Medicaid through information sharing and networking. To complete state coverage, two new regional councils need to be established. The role of the nurse/social worker as the case manager has become more complex with the development of managed care and the increase in culturally diverse populations. Statewide training addressing these and other areas has not been provided in five years. Training to enhance professional skill development and quality assurance activity will be provided once funding is secured. Professional education needs identified include the legal and professional responsibilities of case managers, smoking cessation, delivery of culturally sensitive services, family violence interventions for community-based programs, research

updates about effective substance abuse interventions, and tracking indicators of effective and quality outcomes.

Collaboration is being fostered among individuals and organizations statewide who sponsor Resource Mothers community health workers to increase access to health care services, community-based services and outreach. Virginia Tech, under contract with VDH, has developed a web site map of existing community health workers to be updated annually. A statewide coalition is developing training in core competencies and defining evolving roles of community health workers. A Virginia Center for Sustainable Health Outreach would likely be housed at the Blue Ridge Area Health Education Center (AHEC) at James Madison University.

An Interagency Agreement between VDH and DMAS spells out the responsibilities of each department with regard to the Resource Mothers (called Maternal Outreach in agreement) and Baby Care programs described under Population-Based Services. **(See Appendix D)**

Local PIP coalitions promote collaboration between faith-based, private, nonprofit, and government organizations in their regions to reduce nonmarital births. For FY 00, the coalitions are housed in 6 local health districts and 11 private, nonprofit provider sites. Each cooperates with local schools, colleges, job training programs, gyms, and health clinics to reach young adults and teens in promoting the benefits of waiting until marriage to have children.

Established last year, the OFHS Women's Health Task Team is conducting a survey to document existing VDH women's health programs. Plans are to identify funding opportunities to address women's health issues. The Team's initial scope included assessment of women's health data systems. The need for a PRAMS-like survey has surfaced repeatedly to better assess issues such as substance abuse and domestic violence among perinatal populations.

A Title V representative staff serves on Project LINK's state advisory board committee. The program is discussed under Enabling Services. Unmet needs for substance abusing perinatal patients underscore the importance of this collaborative effort with DMHMRSAS.

Infrastructure: Preventive and Primary Care Services for Children

VDH collaborates with DMAS to implement the Medicaid program (Title XIX) and the Children's Medical Security Insurance Plan (CMSIP/Title XXI). While an Interagency Agreement between VDH and DMAS spells out each agency's responsibilities in relation to EPSDT, it was last revised in 1994 and does not reflect current practices. With the shift to Medicaid managed care, most local health departments are outside of provider networks and subsequently no longer provide EPSDT services. There continues to be an opportunity for the Title V program, including local health departments to participate in outreach and to promote quality EPSDT services in the private sector. The Title V program has initiated a partnership with DMAS to monitor Title V and Title XXI child health access performance measures through a periodic population-based survey. A Title V program representative serves on CMSIP's Outreach Coordinating Committee under the DSS.

The scope of VDH collaboration with DSS in promoting family support has increased over the last two years. In addition to outreach for Medicaid and CMSIP, the Title V program collaborates with DSS for fatherhood initiatives, child abuse prevention, health and safety in child care settings, and abstinence education. A MOA with DSS provides TANF funds for the Virginia Fatherhood Campaign, discussed under Population-Based Services. **(See Appendix D)** A Title V program representative serves on the Advisory Board for the Community-Based Family Resource and Support Program and on the Governor's Advisory Board for Child Abuse and Neglect. Title V program staff also serve on review panels for grants to communities for the Virginia Family Violence Prevention Program and the Community-Based Family Resource and Support Program. These funds help support Enabling Services in some health districts.

VDH maintains MOAs with the Virginia Departments of General Services Division of Consolidated Laboratories, Professional and Occupational Regulation, and Labor and Industry and with the Virginia Institute for Developmental Disabilities and VCU-SERL to implement the Childhood Lead Poisoning Prevention Program discussed under Population-Based Services. VDH program staff provide consultation to the Joint Subcommittee Studying Lead Poisoning Prevention, a legislative committee composed of legislators, citizens including a parent of a child with lead poisoning, a real estate professional, an expert in developing safe building remodeling practices, a lead-abatement contractor, local government and building officials, a physician with expertise in treating lead poisoning, the Director of the Department of Professional and Occupational Regulations, the Commissioner of the Department of Labor and Industry, the Director of the Department of Housing and Community Development, and the Commissioner of Health. In addition, each community with a funded lead poisoning prevention project has a local advisory group that includes parents of children with lead poisoning.

Title V staff in the Center for Injury and Violence Prevention (CIVP) provide leadership to the Virginia Coalition for Childhood Injury Prevention, State Water Safety Coalition, SAFE Playgrounds Committee, and Safe Kids Coalitions. Other Center staff lead the Virginia Child Passenger Safety Coalition and Virginia HNTSA Child Safety Seat Trainers Association and serve on the advisory committee for the Emergency Medical Services for Children Program. The Virginia Coalition for Childhood Injury Prevention consists of approximately 65 individuals representing Virginia agencies and organizations with some injury prevention focus such as the American Red Cross, SAFE KIDS, American Automobile Association, fire departments, Cooperative Extension Service, DOE, DSS, and the Virginia Department of Motor Vehicles. The group meets quarterly to share information and resources, to network and to hear an injury prevention presentation to enhance their local efforts.

Healthy Child Care Virginia is a systems building initiative currently administered by Prince William Health Care Systems to develop integrated health, child care, and social service systems in Virginia. VDH and DSS recently established a MOA for VDH to work with child day care providers to improve health and safety in child day care settings, supported by federal child care development funds. **(See Appendix D)** As a result, the decision was made to transfer primary leadership for Healthy Child Care

Virginia to VDH. This provides a foundation for future infrastructure building to promote health and safety in child day care.

The Title V program maintains a strong collaborative relationship with the DOE, particularly with regard to school nursing services. Collaborative activities include developing and maintaining the School Entrance Health Form (Rev. 1/99) and guidelines for school health services, including *First Aid Guide for School Emergencies* (1998), and *Virginia School Health Guidelines* (1999), as well as special studies. State level Title V and DOE staff meet quarterly with school health representatives and the Virginia Association of School Nurses and publish a newsletter. Title V personnel support special joint projects, such as the publication of school nursing services personnel summary and selected Virginia public school health services components, and the design of a comprehensive school health information system. The School Nurse Institute Partnership, a partnership with VDH, DOE, Virginia Institute for Developmental Disabilities, seven institutions of higher learning, Virginia Association of School Nurses, and Emergency Medical Services for Children, provides statewide school nursing staff development activities.

The *Code of Virginia* requires each school division to have a school health advisory board (SHAB) comprised of broad-based community representatives including parents, students, health professionals, and educators. SHABs assist with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment, and health services. Each board meets at least twice a year and submits an annual report to VDH and DOE on the status and needs of student health in its school division. A 1997 assessment of the SHABs found them to be effective in accomplishing their goals. The Board of Health has called for greater collaboration between local health departments and local school districts in fatherhood education, sexual abstinence education, and reduction of nonmarital pregnancies among teens.

The Title V program's Adolescent Health Task Force includes pediatricians, nurse practitioners, school health service providers, representatives from the legal system, American Cancer Society, American Heart Association, Virginia Association of State School Superintendents, DOE, DSS, DMAS, Office on

Youth, and the DMHMRSAS. The task force meets quarterly to share information and provides consultation and assistance on special projects, such as the VDH Adolescent Health Web site, a speakers' bureau, and conference planning.

Better Beginnings Coalitions in 19 localities strive to raise public awareness on teen pregnancy and its consequences for the community. They support or develop programs to address local teen pregnancy prevention. The Title V program supports these coalitions with funding, training, and guidance.

A MOA with DSS provides TANF funds to support the Abstinence Education Initiative, discussed under Population-Based Services. **(See Appendix D** The program includes a structured process for evaluating the implementation and outcomes of funded community-based programs.

An Interagency Agreement between VDH and DMAS spells out the responsibilities of each department with regard to Teen Pregnancy Prevention Initiative programs described under Population-Based Services. **(See Appendix D)** The State Appropriations Act requires VDH to evaluate the community-based programs to ensure that prevention methodologies are successful and transferable to other health districts, and to report the results of a continuing evaluation to the Governor and Chairs of the House Appropriations and Senate Finance Committees each year.

VDH partners with the Virginia Pediatric Society to distribute child health promotion materials each October. The partnership has expanded to address child day care issues. Formal collaborative mechanisms have not been developed with family practice physicians and nurse practitioners.

Documentation of the high rate of hospitalization for depression, attention to suicide rates, and weakness of the mental health system for CSHCN suggests the potential for collaboration with the DMHMRSAS on mental health issues of children.

Assessment, monitoring, and quality assurance is conducted through private and public sector activities. Through its KIDS COUNT in Virginia project, the Action Alliance for Virginia's Children and Youth

analyzes and disseminates state and local data on the status of children. VDH Title V program staff serve on the KIDS COUNT Advisory Committee and assist with selection and presentation of health data. In addition, VDH's Center for Vital Statistics publishes annual reports of pregnancy, birth, and death data and a special report on teen health. The Center for Injury and Violence Prevention publishes special reports and provides mortality and hospitalization injury data on request. Quantitative data on local health department services are available from VDH's Office of Information Management by special request.

Certain data, however are needed to better assess child and adolescent populations. A statewide survey of youth risk behaviors has not been conducted since 1993. Title V program staff have assisted local health districts or community-based organizations seeking to conduct their own surveys. The Adolescent Health Task Force and the Governor's Right Choices for Youth Initiative have brought attention to this need.

Child nutrition services are monitored in conjunction with WIC program evaluations. The Division of Dental Health has plans to implement a quality assurance program for the public health dental services. Since the 1994 discontinuance of the Program for Excellence there is no active statewide plan for monitoring the quality of clinical child health services provided by local health departments. *MCH Guidelines* (1992), the guidance document for maternal and child health care service provisions in local health departments, is out of date. A committee of local health department and central office representatives is exploring options to meet the need for clinical services guidelines.

The *Code of Virginia* establishes the State Child Fatality Review Team (CFRT) and directs the team to review violent and unnatural child deaths, sudden child deaths occurring within the first 18 months of life, and child fatalities where the cause or manner of death was not determined with reasonable medical certainty. Chaired by the Chief Medical Examiner, the 16-member team includes the following persons or their designees: the Commissioner of the DMHMRSAS; the Director of Child Protective Services within the DSS; the Superintendent of Public Instruction; the State Registrar of Vital Records; and the Director of the Department of Criminal Justice Services. In addition, the Governor appoints one

representative from each of the following entities for a three-year term: local law-enforcement agencies, local fire departments, local DSS, the Medical Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Pediatric Society, Virginia SIDS Alliance, local emergency medical services personnel, Commonwealth's attorneys, and CSBs. Title V block grant funds provide part-time staff support for the team. The CFRT receives additional support from a CISS grant. This project strengthens collaboration between the CFRT and the Title V program.

Infrastructure: Services for Children with Special Health Care Needs

The *Code of Virginia* gives authority for the Commissioner of Health to appoint an Advisory Board for Genetics, Metabolic, Endocrine and other Inherited Disorders. Representatives from the four genetics centers, including geneticists, the DOE, DMHMRSAS, and VDH serve on this advisory committee. The need to increase family participation is being remediated through current recruitment efforts. Genetics issues addressed by the board include the addition and/or deletion newborn screening tests, such as congenital adrenal hyperplasia, adding mass spectrometry in the newborn screening laboratory, Maternal Serum Alpha Feto Protein (MSAFP) issues, reimbursement for genetics services, and issues regarding the Human Genome Project. The need to be better integrated within VDH and be more connected with health department issues constitutes a concern of the genetics advisory board.

The Virginia Hearing Impairment Identification and Monitoring System (VAHIIMS) is guided by an active advisory committee, established by the *Code of Virginia* and appointed by the State Health Commissioner, to assist in system design, implementation, and revisions. Board representatives include the health insurance industry; physicians, including at least one pediatrician or family practitioner, one otolaryngologist, and one neonatologist; nurses representing newborn nurseries; audiologists; hearing aid dealers and fitters; teachers of the deaf and hard-of-hearing; parents of deaf or hard-of-hearing children, deaf or hard-of-hearing adults, hospital administrators; local public health departments, civic organizations, and personnel of appropriate state agencies, including DMAS, DOE, and the Department for the Deaf and Hard-of-Hearing. The *Code* directs the DOE, the Department for the Deaf and Hard-of-Hearing, and DMHMRSAS to cooperate with VDH in system implementation.

The *Code of Virginia* gives authority for the Governor to appoint a Hemophilia Advisory Board to consult with the Board of Health in the administration of the Hemophilia Program. This Board is composed of seven persons, one representative each from hospitals, medical schools, blood banks, voluntary agencies interested in hemophilia, local public health agencies, medical specialists in hemophilia, and the general public. Family participation is provided via the representative from the voluntary agency, the United Virginia Chapter of the national Hemophilia Foundation and the general public.

VDH maintains an agreement with the Department of Education (DOE) to have educational consultants as members of the interdisciplinary teams in CDC and CSS clinics. The consultants provide liaison services among the clinics, the children's families and local education agencies serving the children. Duties include administering and interpreting developmental and/or educational evaluations; identifying learning styles, strengths, and weaknesses; recommending educational strategies and modifications; consulting with school personnel regarding modifications in school programs; monitoring and reevaluating progress of the children; and providing staff development. DOE provides the position and funding and contracts with a local school division to provide the supervision and fiscal management of the position. VDH provides the housing and secretarial support and participates in the evaluation of the Educational Consultant.

The Title V program has established and maintains ongoing interagency collaboration for systems building in some defined areas. The Title V program collaborates with DOE to develop and maintain guidelines for school health services for CSHCN, such as *Guidelines for Specialized Health Care Procedures* (1996) and "Guidelines for Training Public School Employees in the Administration of Insulin and Glucagon (1999)." VDH and the Virginia Chapter of the American Lung Association have established the Virginia Asthma Coalition to assess needs, share information, and collaborate on the use of available resources.

VDH maintains contracts with DMAS for CSS and CDC to provide Medicaid and CMSIP services on a fee-for-service basis. Title V program staff participate in an interagency group organized by the DMAS to discuss issues of common interest for Medicaid special needs populations.

The Community Services Act (CSA) State Executive Council and State Management Team and the Virginia Interagency Coordinating Council (VICC) are formal structures for interagency collaboration to address systems issues for some segments of the CSHCN population.

In 1998 VDH established a CSHCN Task Force to provide consultation for an initiative to assess and improve the Commonwealth's systems of care for children with special health care needs. The task force was composed of a full range of state agencies serving children, including the VDH, DMHMRSAS, DOE, and DMAS; key providers from major medical centers; private practice physicians; managed care organization representatives; and parents and family advocates. The CSHCN Task Force completed its work in early 1999.

The needs assessment found that many of the current system's problems are a result of fragmented policies and programs, developed and implemented in isolation, that are neither focused on the whole child nor centered on the whole family. A major recommendation of the study was to organize and convene a State Interagency Public/Private CSHCN Council, to provide a formal vehicle for pursuing system redesign and improvements and to foster coordinated and collaborative partnerships among stakeholders in the public and private sectors.

The *Code of Virginia* establishes Community Services for At-risk Youth and Their Families (CSA), a collaborative system of services and funding that is child-centered, family-focused, and community-based to address needs of troubled and at-risk youths and their families in the Commonwealth. Its strives to ensure that services and funding work to preserve families and operate in the least restrictive environment while protecting children's welfare and maintaining public safety. The CSA seeks to identify and intervene early with young children and their families who are at risk of developing emotional or behavioral problems. The Act promotes increasing private partnerships in service delivery and provides

communities flexibility in fund allocations and decision making while maintaining accountability. The state CSA funds are pooled from various state agencies. The pooled funds include DSS state and local foster care and purchased foster care funds, 286 and 239 special placement funds from the Department of Juvenile Justice, Department of Education's private tuition funds and the DMHMRSAS funding for purchased beds for adolescents. There is a local cash match required to access the state CSA funds. Children who would have been served by one of these funding streams are designated as targeted for priority services. The Commissioners from VDH, DMHMRSAS, and DSS; the Superintendent of Public Instruction; the Executive Secretary of the Virginia Supreme Court; the Director of the Department of Juvenile Justice; an elected or appointed local official; a private provider representative as a nonvoting, ex officio member; and a parent representative serve as the CSA state executive council. In addition, representatives from these agencies and groups comprise a State Management Team, Community Policy and Management Teams (CPMTs), and Community Family Assessment and Planning Teams (FAPTs). A Title V program staff person represents VDH on the State Management Team. All local health departments serve on CPMTs and FAPTs.

The Title V program currently coordinates health services on an individual basis for low-income families with CSHCN through its Children's Specialty Services, Child Development Clinics, Genetics Centers, and Metabolic Treatment Centers. These programs are described under Direct Services and Population-Based Services.

The CSHCN Task Force study recommended continued support for specialty medical care through Virginia's high-quality tertiary institutions, with funding dedicated to service expansion and enhancement. Specifically, it suggested that hospitals by region should compete for designation as CSHCN Centers of Excellence and that performance-based contracts be negotiated between the State and these centers. In addition to continued provision of specialty medical services, these contracts would promote institutional leadership in the areas of improved coordination between primary and specialty care, improved care coordination, and developed quality improvement activities, such as CSHCN provider continuing education, regional needs assessment, and systems-related studies of issues of concern to CSHCN and their families.

After thorough review of the study, Title V central office staff agreed that total needs of this population could be more efficiently managed through a transition of program services to regional entities. To effectively build a regional delivery model, Title V staff researched similar models in states such as Connecticut and Pennsylvania. Through an analysis of internal infrastructure, political environment, and financial constraints the Title V staff will proceed with service transition and institutional contracting through a deliberate phased-in approach which will guarantee seamless service delivery to this vulnerable population.

Formal statewide mechanisms in communities for coordination and service integration among programs serving CSHCN are limited to young children with special developmental needs. The *Code of Virginia* creates the Virginia Interagency Coordinating Council (VICC) to promote and coordinate early intervention services in the state. The VICC is comprised of parents of infants and toddlers with disabilities, public or private providers of early intervention services, a Virginia General Assembly member, representatives from relevant State agencies, and a Head Start agency or program member. Title V staff provide VDH representation on the VICC.

The *Code* also provides for local interagency councils on a statewide basis to enable early intervention service providers to establish working relationships that will increase the efficiency and effectiveness of those services. Membership on the local councils includes designees who are authorized to make policy decisions from the CSB, VDH, DSS, and local school division as well as community service providers and at least one parent. VDH maintains a MOA with the DMHMRSAS for participation in the IDEA-Part C service system, including coordination and utilization of available services for children birth to three years of age at the community level. **(See Appendix D)**

Infrastructure: All Title V Populations

With a focus on strengthening the public health core functions of assessment, policy development and assurance, VDH, in partnership with the Virginia Hospital and Healthcare Association, was awarded a

Turning Point grant from the Robert Wood Johnson and W.K. Kellogg foundations in 1998. Turning Point is a strategic planning initiative for strengthening and transforming community health in the Commonwealth. Public and private sectors have been engaged in this effort to help evaluate both traditional and emerging public health roles such as quality of care and strengthening families.

As part of its focus on partnerships and community involvement, Turning Point conducted an initial assessment in 1998 to gather community and other stakeholders input which included telephone surveys, key informant interviews, and regional public forums. From these activities, the need for health education, communication, and promotion activities to ensure that families and individuals can make informed decisions regarding lifestyle and wellness issues that affect their health was an identified critical community health concern. In addition, the 1998 assessment found that one of the continued roles for public health should be to ensure access to quality health services for all individuals regardless of ability to pay, although it was not felt that local health departments necessarily needed to be the direct providers of these services.

Turning Point plays an important part in infrastructure building as it seeks to strengthen the perceived value and defined role of public health by improving decision makers' understanding of contributions of public health and its partners. This includes cultivating a shared ownership of public health where both the private and public sectors work together to improve and solidify a strong future for public health. In addition, the initiative builds capacity through promoting collection, analysis, and sharing of health-related data to be used as the foundation for information-based community decisions. Another infrastructure related goal of Turning Point is to ensure that the public health work force has the skills needed in the future.

With additional recently awarded Robert Wood Johnson Foundation funds, Virginia will serve as the lead of seven participating states to promote collaborative leadership to achieve policy and system changes to maximize the public's health. The Commonwealth will begin implementing a four-year Community Health Improvement plan. The plan includes identifying levels of community capacity,

performing community health needs assessments, assessing the economics of prevention, providing social marketing training, and promoting public health awareness.

With the further penetration of managed care into Virginia, VDH has developed partnerships with managed care stakeholders and enhanced its own internal infrastructure to improve its assessment, quality assurance and policy development functions as they relate to managed care. VDH has identified a need to further assist local health departments in their relationships with managed care organizations. While OFHS had previously convened a managed care team, the prominence of these issues led to the recent formation of a Commissioner-level managed care team. The recreated managed care team includes a newly designed position for a managed care policy analyst within the OFHS, the executive advisor to the Assistant Commissioner for Community Health Services (AC-CHS), and a Human Services Program Director. This team has responsibility for public health core functions related to managed care.

Funded by Title V, the managed care policy analyst performs quality assurance, program development, and policy development functions. This analyst provides leadership for analysis of legislation, public and private accreditation reporting requirements, regulatory proposals, and economic/operational impact. The Title V program person establishes and maintains collaborative relationships with DMAS and Center for Quality Health Care Services and Consumer Protection (CQHSCP). As DMAS prepares for renegotiations with managed care organizations for Medallion II and Options contracts, VDH's representative will provide input to ensure that MCH interests are addressed. Included in the analyst's responsibilities are review of the Medicaid State Plan as well as development of managed care products for VDH divisions and local health departments.

The AC-CHS executive advisor has taken the role as a contract specialist. In the past local health departments have largely negotiated contracts individually. Formalized assistance has been initiated to help local districts develop negotiating skills, which will improve previously identified concerns relating to reimbursement, quality assurance, and role definition. Whether unique or statewide contracts best serve MCH interests is also being explored. The Human Services Program Manager has primary responsibility

for developing and maintaining partnerships with managed care organizations. Local health departments with managed care contracts are convened every few months to share best practices and discuss problems. This redesign has strengthened VDH's internal and external capacity to work successfully in the managed care environment and advocate for MCH populations.

The Prenatal, Infant, Children and Special Needs Committee (PICS), convened by DMAS, includes VDH Title V representation from the Commissioner-level managed care team as well as Title V program management staff. This group has brought together private sector managed care organizations along with public sector stakeholders including VDH, DMAS, DSS, DMHMRSAS, and Department of Vocational Rehabilitation. PICS addresses concerns regarding the managed care system and its services affecting the MCH population. PICS functions include best practices identification, clinical guidelines development, provider education, service delivery problem identification and management, and utilization and reimbursement analysis. Needs identified by this group relate to improving early entry into care for Medicaid eligible pregnant women and identification of CSHCN. PICS has been instrumental in facilitating plan development to decrease Medicaid application processing times, which have been linked to delays in prenatal care as well as other services. Collaborative efforts have resulted between VDH and DMAS to better identify and link CSHCN with appropriate medical plans and services.

Legislation enacted in 1998 will require every managed care health insurance plan operating in Virginia to request a certificate of quality assurance starting July 2000 from VDH through its Center for Quality Health Care Services and Consumer Protection (CQHSCP). In order to receive this certificate, a managed care health insurance plan must have in place reasonable policies and procedures to encourage the appropriate provision and use of preventive services for its covered persons and reasonable and adequate systems to assess, measure, and improve the health status of covered persons which include outcome measures. These quality improvement programs must target acute and chronic illnesses, promote prevention, and recognize identified public health goals. A Title V program representative helped review proposed state regulations to ensure adequate MCH representation. The Title V representative works collaboratively with CQHSCP for continued efforts in assuring quality services for MCH populations.

Passed in the 2000 Virginia General Assembly Session, SB 533 requires all HMOs providing services in the state to submit Health Employer Data and Information Set (HEDIS) or other quality of care or performance information sets approved by the Board of Health to the Commissioner of Health. This will enable VDH to fulfill its monitoring and quality assurance functions.

In addition, VDH is part of the DSS Interagency Planning Group which meets to help uncover needs of the TANF population and how TANF dollars may be used to alleviate those needs. The group includes staff from VDH, DSS (state and local), DOE, DMHMRSAS, Department of Rehabilitative Services, and the Governor's Employment and Training Department. Under a Memorandum of Agreement (MOA), DSS has contracted the VDH Human Services Program Director (Eletta Heath-Hanson) to assess the TANF population's health care status. DSS and VDH are collaborating to find an identifier, which can be used to define the TANF population and link assessment data from each agencies respective databases, including the state hospitalization database which VDH accesses. This will enable an accurate evaluation of the specific TANF cohort, versus one more broadly defined. Concerns over complying with the Health Insurance Portability and Accountability Act of 1996 (Kennedy-Kassenbaum) are being currently addressed. Preliminary local surveys have revealed that local departments of health and social services could better assist linking TANF clients with needed health services through improved identification, stronger communication and resource promotion.

The Office of the Chief Medical Examiner (OCME) received a grant from the MCH Bureau in 1998 to promote collaboration among various morbidity and mortality review programs within Virginia. Guiding the Mortality/Morbidity Review Project (MMRP), an advisory group of representatives from the OCME, OFHS, local Child Fatality Review Teams, FIMR programs, child advocacy groups, ACOG, and RPCs meets quarterly to discuss areas of concern, share expertise, identify areas for collaboration, and to increase visibility and impact of mortality reviews. The MMRP strives to provide data pertinent to prioritization of maternal and child health issues. The MMRP promotes cross participation and sharing of results and recommendations among local mortality review groups including FIMRs, their Community Action Teams (CATs), and Child Fatality Review Teams (CFRTs). Integration of review processes,

such as maternal mortality, constitutes another infrastructure-related objective of the MMRP. To address the identified need for improved access to ME records, a protocol for FIMR access has been developed and implemented along with training. New state legislation in 1999 authorized local child fatality review and intimate partner fatality review. The group, however, has identified the lack of legislative authority to conduct FIMR and maternal mortality reviews as a concern.

The MultiCultural Health Task Force (MCHTF) is aimed at identifying the health care needs of Virginia's racial and ethnic populations, and the public health system's capacity to provide culturally competent services. Funded in part by the State Systems Development Initiative (SSDI) grant from the MCH Bureau, the project has worked closely with VDH Offices of Minority Health, Primary Care and Rural Health, Epidemiology, and Health Policy. The MCHTF Research Initiative was discussed under Enabling Services. The MCHTF provides a forum among agencies for resource sharing, problem identification and strategy implementation, linkage and network strengthening, research analysis "Think Tank" for multicultural health issues, funding opportunities, expanded targeting of multicultural groups, and information dissemination through training/presentation opportunities. MCHTF has plans to expand membership and collaborate with other agencies serving multicultural populations, such as DSS, DMAS, DMHMRSAS, and AHECS which all have been handed the challenge of eliminating disparities and increasing access to services to 100 percent by 2010 by the U.S. Health Resources and Services Administration (HRSA).

To guide the Title V program and expand the infrastructure capability to regularly gather family and consumer input, OFHS has recently initiated a Family and Community Health Advisory Committee. This committee has representatives from different geographical regions, major players among the health professions, medical schools, and those groups concerned with the populations served by the grants. The group will assist with the core function of assessment. They helped with data review and issue identification for the FY 01 Title V needs assessment. In addition, they will also make recommendations for grant applications, program priorities, and other public health issues pertinent to Virginia's MCH population.

Chaired by the Secretary of Health and Human Resources, the Virginia Maternal and Child Health Council was established in 1992 to improve the health of mothers and children by promoting and bettering maternal and child health programs and service delivery systems. The Council, however, has not met since 1998. OFHS remains available to provide Title V staff support to the Council. Members include the Commissioner of Health, the Director of DMAS, the Commissioner of DSS, the Superintendent of Public Instruction, the Commissioner of DMHMRSAS, two legislative members, and 11 appointees of the Governor from various areas such as hospitals and the religious community. Activities under the Council's mission include examining trends in maternal and child morbidity and mortality, identifying maternal and child health problems and issues, such as fragmentation and gaps in services and programs, promoting public-private partnerships or systems of care, and coordination of maternal and child health related agency efforts.

3.2 Health Status Indicators

(See Section 5.4 for Core Health Status Indicator Forms, Section 5.5 for Core Health Status Indicator Detail Sheets and Section 5.6 and 5.7 for Developmental Health Status Indicator Forms and Detail Sheets)

3.2.1 Priority Needs

Virginia's Title V program has been challenged by economic, social, and political forces that have dramatically changed the provision of healthcare. In the past five years, close to one third of all Virginians, as well as nearly half of those with Medicaid, have shifted to managed care. While the state has flourished economically, welfare reform has likely contributed to increasing proportions of women without health insurance, although the overall proportion of the uninsured, including children, has decreased. Communities continue to experience increases in non-marital births and an influx of many new multicultural populations entering the state. Market forces and recently enacted laws have forced public health along with the Title V program, to reevaluate priorities, the allocation of resources, and the strategies used to achieve optimum health.

The needs assessment was a way for the Title V program to analyze these changes and examine health status for the populations it serves. Consequently, the priorities developed help guide Title V in addressing concerns that have arisen in this new environment. **Improving access to health services and health insurance, improving health outcomes by strengthening families, and improving the quality of clinical, preventive, and community-based services** are important priorities for Virginians. Revamped state negotiated performance measures (SPMs) also reflect the direction of the program based on the needs assessment and new priorities.

While public health and the Title V program have assumed the role of enhanced assessment, quality assurance, redesigning the public health infrastructure, part of **improving access to health services** still requires direct service. Meeting the needs of vulnerable populations, such as children with special health care needs (CSHCN) and uninsured pregnant women has not relieved health departments from providing direct services. While the number of patients served by clinics has fallen, particularly for Medicaid clients, health departments still operate as medical care providers and function as a safety net in many communities with limited resources. Maintaining reduced or basic services requires a base staffing level. As in the past, Title V remains the primary funding for health department sponsored CSHCN services and clinical preventive care services for pregnant women, infants and children for low income populations.

The needs assessment has lead VDH to focus on **promoting healthy behaviors, improving health outcomes by strengthening families, and reducing racial and ethnic disparities**. To meet these needs, however, additional funds from Temporary Assistance for Needy Families (TANF), Virginia General Assembly, the Department of Medical Assistance, and the Department of Social Services have been required to supplement Title V dollars. Initiatives such as the Virginia Fatherhood Campaign and Partners in Prevention, address the critical importance of families.

Needs assessment data reinforced the OFHS and Title V priority **to improve health outcomes by strengthening families**. Maternal and child health data highlighted the correlation between family structure and access to and utilization of health care. The lowest rates of health insurance for both

pregnant women and children were found among single parent families. Consequently, these populations were less likely to seek early prenatal care, obtain any prenatal care, and have a regular medical home. Low weight births and infant mortality to unmarried mothers were almost twice the rate of married mothers.

The importance of strengthening families has become a critical priority with nonmarital births increasing in Virginia and across the nation. The proportion of families with children headed by a single parent and the percent of nonmarital births in the Commonwealth have continued rising. Poor mental and physical health, lower educational attainment and poverty will adversely affect the children of these women.

Needs assessment data support the continuation of these efforts. The reduction in teenage pregnancies, particularly in the under 18 age cohort, presents a success in strengthening families. This is critical since four-fifths of these births are nonmarital. Conversely, the data showing nearly half of all births to young adults aged 20-24 occurring outside of marriage reinforces the need to heighten promotion of marriage benefits and nonmarital pregnancy prevention efforts. Measuring the *percent of nonmarital births* (SPM # 5) will continue state assessment efforts in this area.

Programs and resources geared to strengthening families have been increasingly supported over the past five years. Resource Mothers and the Baby Care Program provide case management and mentoring for pregnant teenagers and other high-risk mothers. Resource Mothers has had documented success in delaying repeat pregnancies and thus helping to ameliorate further negative economic and social consequences of teenage parenthood. Better Beginnings and Teen Pregnancy Prevention Initiative community coalitions also help carry out the mission to strengthen families through community-based prevention activities. The Virginia Abstinence Education Initiative promotes abstinence until marriage among school age children. The Partners in Prevention Initiative emphasizes the benefits of waiting until to marriage to conceive and bear children with a special emphasis on young adults who have been traditionally neglected from programming. In addition, with the switch to serving families versus specific populations, the Virginia Fatherhood Campaign has worked to promote the benefits of fathers in their

children's lives. Through the Virginia Healthy Start Initiative, Resource Mothers has been expanded to include Resource Fathers.

Continuing health status improvements in the past five years were evidenced by declining rates of infant and child mortality. These benefits have not been uniformly enjoyed by all segments of the maternal and child health population. Data showed minorities faring worse than whites in nearly all access and outcome indicators. Minority health takes on increased importance since Virginia continues to experience growing Asian and Hispanic populations. In 1998, Hispanics demonstrated the lowest proportion of first trimester prenatal care utilization. This may be related to fear of contact with governmental and medical systems, language barriers, and lack of resources or knowledge. The worst outcomes, however, continue to be experienced by blacks in the Commonwealth. In fact, the gap in the infant mortality ratio between whites and blacks has increased in the past several years. Large disparities were observed in rates of low weight births, infant mortality, HIV infection, sexually transmitted diseases, teenage pregnancy, induced terminations, and homicides. Better overall health status for all Virginians remains incumbent on the ability to reduce these disparities.

In response to these trends, OFHS has sponsored the MultiCultural Health Task Force which conducted a many-faceted research initiative to identify health care needs among racial and ethnic populations from both consumer and provider perspectives. Language emerged as a top barrier. Service providers identified needs to improve their capabilities to handle non-English speaking populations through additional translators, bilingual staff, and translated patient materials available from a centralized location. Language, however, was only one of several important needs identified. Cultural competency training and resources to conduct community outreach were among other issues named. Consumers and providers cited traditional barriers to service such as poverty, lack of insurance, and transportation. Consumers also expressed difficulty in navigating complex systems of health care and differences in resource availability and importance of health care in comparison to their countries of origin. Strengthening health providers' ability to competently serve persons from multicultural backgrounds will make better use of the resources and improve outcomes.

Data analysis also highlighted relationships between underserved areas and minority populations. Selected indicators and outcomes were utilized to identify perinatal underserved areas, a concept that encompasses both resource and underutilization patterns. Many of the 52 communities identified as perinatal underserved have high proportions of minorities, particularly blacks, and are lacking in adequate preventive health services. In addition, many of these communities also experience higher than average proportions of teen and nonmarital births. This data has helped Regional Perinatal Councils (RPCs) better direct their efforts to specific community problems. To better target resources to reduce racial and ethnic disparities, the Virginia Healthy Start Initiative (VHSI) recently received funds to extend work in three communities with large disparities. To monitor progress, Virginia has adopted two new SPMs (#12,13), which *measure the percent of low weight births for African Americans in perinatal underserved areas and the percent of pregnant women in Virginia's perinatal underserved areas receiving adequate prenatal care*. These measures fit with the Title V priority **to reduce racial and ethnic disparities** as well as **improving access to health services and health insurance.**

Insurance status remains a prime indicator for health care utilization as evidenced by survey and birth certificate data. **Promoting access to care** remains a priority. Improvements have been observed in the proportion of uninsured children, but the underutilization of insurance available for children in low-income working families remains a focus for future efforts. Reducing delays in obtaining Medicaid and thereby increasing the likelihood that early prenatal care will be obtained also continues to be important. Medicaid patients, and those with no payment source, exhibited poorer care utilization and outcomes. Decreasing the time it takes to process applications is one important strategy to increase access to care. VDH has joined an interagency group, Prenatal, Infant, Children and Special Needs Committee (PICS), which will help develop the infrastructure and provide a forum to make systems-based changes. In addition, VDH's role will continue to increase as the state moves to implement a new Title XXI program for uninsured children, Family Access to Medical Insurance Security Plan (FAMIS).

PICS and other similar partnerships exemplify the evolving role from clinical provider to assurer of quality services. Title V has made **improving the quality of clinical, preventive, and community-**

based services a priority. Recent changes in the *Code of Virginia* have legislated and solidified that role as evidenced by VDH now regulating managed care plans in the Commonwealth through licensure and collection of quality assurance (HEDIS) data.

Accurate and successful assessment requires adequate data. The needs assessment identified gaps in data for measuring health behaviors among pregnant women and adolescents. Virginia will require assistance to identify ways to get a more complete picture of the health status of this population. State health officials have been working with health districts and community groups to assist them in collecting this data. This will be measured by a new SPM (#10), *percent of school districts that have completed a survey within the past five years to measure health-related behavior*. As the role of quality assurance and monitoring continues, providing appropriate and timely data will become a prime function of public health. The Turning Point Initiative also supports this priority. OFHS and the Title V program have made it a priority **to develop its capacity to meet customers' needs for accurate, reliable, timely and relevant public health information and assure its use in decision making.**

Promotion of healthy behaviors encompasses a variety of issues such as nutrition, immunizations, and sexual behavior. Needs assessment data revealed the impact these behaviors or their absence on health outcomes. For example, as immunizations have increased, cases of most vaccine-preventable diseases have decreased with chicken pox cases. Promoting healthy behaviors has emerged as a priority for clinical as well as educational and awareness programs. Data from BRFFS surveys and WIC program participants highlighted concerns over nutrition practices of maternal and child health populations and their potential sequelae such as weight problems and osteoporosis. With a statewide media campaign promoting folic acid consumption and a recent drop in neural tube defects, the potential to influence positive health outcomes through healthy behavior promotion appears to be a challenging yet attainable objective. Risky behaviors such as smoking, substance abuse, and domestic violence, are concerns arising in the limited data available.

Fetal Infant Mortality Reviews (FIMR) and Child Fatality Review Teams (CFRT), have greatly increased in the past five years. Maternal and Child Health Bureau funding has supported coordination

and information sharing among these teams through the Office of the Chief Medical Examiner (OCME). Review of mortality and morbidity reinforces a Title V focus on unintentional injury, which remains one of the biggest threats to children's health. While these deaths have declined in the past five years, they still account for four out of ten deaths for children aged 1-14. The majority of these deaths are related to motor vehicle crashes. Unintentional injuries are also a major cause for hospitalizations and rank as the top cause among children aged 10-14.

The Center for Injury and Violence Prevention was recently created within OFHS to reduce injuries that are preventable. Led by the OCME, the Child Fatality Review Team reviewed 1994 firearm deaths and found that they disproportionately affect males and blacks and that nearly half were preventable. Progress in promoting healthy behaviors will be measured by two SPMs (#6, #7), *the number of unintentional injury hospitalizations (children aged 1-14) and the number of assault injury hospitalizations (youth aged 10-19).*

One of the most vulnerable populations, children with special health care needs (CSHCN), remain as a major priority, receiving a large proportion of Title V funds. Numerous special health care needs, e.g., emotional disturbance, asthma, and sickle cell anemia, affect from thousands of Virginia children. A 1999 comprehensive needs assessment found that the quality and depth of available medical services in the state was well rated by families with CSHCN. However, the report cited support services for families, services which value family input, and adequately coordinated and integrated systems of care as unmet needs.

Recommendations to establish Regional Resource Centers and a statewide Family to Family Network were made to help provide centrally organized and family-centered services. A special interagency CSHCN Task Force also recommended organizing and convening a State Interagency Public/Private CSHCN Council to better serve CSHCN. Further recommendations to revise service delivery models, such as establishing comprehensive CSHCN centers, are still being considered.

The Title V program currently coordinates health services on an individual basis for low-income families with CSHCN through its Children's Specialty Services, Child Development Clinics, Genetics Centers, and Metabolic Treatment Centers. The Newborn Screening Program, Sickle Cell Program, Virginia Hearing Impairment Identification and Monitoring System (VAHIIMS), and the Virginia Congenital Anomalies Reporting and Education System (VaCARES) are health department programs which help determine CSHCN. There is no systematic statewide mechanism to identify all children with conditions and illnesses that limit their ability to function. Title V has made **improving identification of "at-risk" populations and assuring linkage with prevention and early intervention** a priority. Work continues to expand the newly developed hearing screening program to all infants born in the state. Efforts to enhance the infrastructure and modify the service delivery model for CSHCN will continue and be based on community and family input. VDH maintains its role with the PICS interagency group to ensure that CSHCN within Medicaid managed care settings are adequately identified and managed. Data collection, integrated data systems, and follow up also are central areas of focus. This priority has been built into a new SPM (#11), *percent of infants screened for genetic diseases and hearing loss who received recommended follow-up services.*

During the recent OFHS strategic planning process, the OFHS Management Team reviewed the FY 00 Title V priorities as well as the needs assessment data. The management team adopted the following priorities for all of OFHS as well as priorities for Virginia's Title V efforts. The new state performance measures are discussed in Section 3.4.2.2. Title V efforts will focus on Virginia's families including women of childbearing age, pregnant women, infants, children, adolescents, and CSHCN. In addition, the Management Team adopted the OFHS priority to enhance the effectiveness and efficiency of OFHS performance.

1. Improve health outcomes by strengthening families.
2. Improve the quality of clinical, preventive and community-based services.

3. Develop the capacity to meet customers' needs for accurate, reliable, timely and relevant public health information and assure its use in decision-making.
4. Improve access to health services and health insurance.
5. Improve identification of "at risk" populations and assure linkage with prevention and early intervention.
6. Reduce (racial/ethnic) minority disparities in health status.
7. Promote healthy behaviors.

The list of priorities is also included on Form 14, Section 5.8.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

(See Forms 2, 3, 4, and 5 in Section 5.8)

3.3.2 Other Requirements

1. USE OF FUNDS TO CARRY OUT THE ANNUAL PLAN

a. **Prevention and Primary Care Services For Pregnant Women and Mothers Over 21 Years of Age**

Federal funds are designated for preventive and primary care services for pregnant women and mothers. Specifically, these services include the following:

Policy and procedural oversight concerning women's services
Nutrition services for women
Contracts to local health departments for maternal health services
Pharmacy and laboratory testing for pregnant women

Regional Perinatal Coordinating Council to include professional outreach education and Fetal Infant Mortality Review (FIMR)

b. **Prevention and Primary Care Services for Infants Under 1 Year of Age**

Prevention and primary care services for infants are budgeted. Specifically, these services include:

Policy and procedural oversight concerning infant services
Contracts to local health departments for infant health services
Regional Perinatal Coordinating Council to include professional outreach education
Newborn screening

c. **Prevention and Primary Care Services for Children and Adolescents from 1 Year Not to Exceed 21 Years of Age**

Funds for prevention and primary care services for children and adolescents include activities aimed at reducing the incidence of health problems and the prevalence of community and risk factors for these problems. The promotion of health and the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, and the overall management responsibility of secondary and tertiary care. Specific services include:

Policy and procedural oversight concerning child and adolescent program development
Nutrition services
Child and adolescent health programs including injury prevention, lead poisoning, Resource Mothers Program, primary care initiatives, and school health
Family planning services for patients under age 22 and teen pregnancy prevention projects
Maternal health services for patients under age 22
Laboratory testing and pharmacy services, sickle cell services
Fatherhood initiatives

Dental health education and assessment

Partners in Prevention initiatives to reduce out-of-wedlock births to children and adolescents 10-21 years of age

d. **Prevention and Primary Services for Non-Pregnant Women of Childbearing Age Exceeding 21 Years of Age**

Funds dedicated to serve this population include the following services:

Policy and procedural oversight concerning women's services

Contracts to local health departments for family planning services

Laboratory testing and pharmacy services

Partners in Prevention initiatives to reduce out-of-wedlock births to women 21-29

e. **Children with Special Health Care Needs**

Services for children with special health care needs include family-centered, community-based coordinated care for persons from birth through age 20 who have or are at risk for disabilities, handicapping conditions, chronic illnesses and conditions or health related educational or behavioral problems. Services also include the development of community-based systems of care for such children and their families. Examples are:

Specialized medical-surgical care programs

Care coordination

Interdisciplinary diagnostic evaluations

Follow-up services

Inpatient hospitalization

Outpatient surgery

Pharmacy services

X-ray and laboratory services

Supplies and equipment

Therapies (physical, occupational, speech and aural)

Genetic testing, counseling and education

Nutrition services

2. ADMINISTRATIVE COST LIMIT

Agency administrative costs are those incurred by the Virginia Department of Health in the administration of federal and other grants by individuals other than those employed for the sole purpose of support for the grant. As in previous applications, the FY 01 Budget does not include funds for administrative costs. The definition of administrative costs adopted by the Virginia Department of Health relative to the Title V Block Grant includes the following cost components:

a. Overall agency management and policy direction for the Title V Block Grant.

b. Agency provision of accounting, budgeting, payroll, financial control, and financial reporting services as required for the grant by individuals other than those employed for the sole purpose of support for the grant.

c. Personnel services, including classification and compensation management, grievance handling, recruitment and referral of applicants, program monitoring for equal employment opportunity, standards of conduct and employee performance evaluation.

d. Support services for the provision of essential supplies, equipment, mail, materials, and technical assistance.

3. "30-30" MINIMUM FUNDING REQUIREMENTS

As required by Section 505 of Title V, the state will budget at least 30 percent of the total federal allocation for preventive and primary care services for children. Also, at least 30 percent of the total federal allocation for family-centered, community-based, coordinated care for children with special health care needs, and the development of community-based systems of care for such children and their families. As shown in Budget Form 2, $4,576,283 or approximately 35.9 percent of the total budgeted federal funds of $12,764,996 will be used for preventive and primary care services for children

(including infants) and adolescents; $5,786,140 or approximately 45.3 percent of the total will be used for children with special health care needs. The remaining 18.8 percent of the total budgeted federal funds or $2,402,573 will be used for preventive and primary care services for pregnant women, mothers, and non-pregnant women over 21 years.

4. MAINTENANCE OF STATE EFFORT

The funds provided by the state for fiscal year 2001 for maternal and child health services are at a level that exceeds the fiscal year 1989 level. During the period October 1988 through September 30, 1989, $8,718,003 in state funds for Title V maternal and child health services were expended; this compares to the fiscal year 2001 allocation of $11,598,037 in state funds for these services. During federal fiscal year 1989, a total of $9,033,260 in federal funds was expended and the Commonwealth of Virginia overmatched the 4:3 requirement by $1,943,058.

The amount of state funds expended in fiscal year 1989 was determined by including all state funds used for the Title V match and overmatch for all Title V-funded units, and for the childhood immunization program. The state has an established fiscal management system to ensure a clear audit trail. A specific program coding number is assigned to each program, which is not duplicated. The program director or designee reviews all requests for payments. All new financial systems used by the Department of Health are reviewed by internal and state auditors prior to implementation and receive the approval of the State Auditor's Office. The State Auditor's Office audits all federal programs yearly and its report is forwarded to federal program officials.

5. TARGETING FUNDS TO MANDATED TITLE V ACTIVITIES

Title V funds are used to carry out the purposes of this title and the following activities previously conducted under the Consolidated Health Programs:

a. Lead poisoning prevention - Five programs currently receive funds through a CDC state and Community-Based Childhood Lead Poisoning Prevention Program grant.

Title V funds are used to provide programmatic and administrative direction and support to this program.

b. Genetics - The three original programs located at the University of Virginia, Medical College of Virginia, and Medical College of Hampton Roads and a fourth genetics center, the Fairfax Genetics and IVF Institute, currently receive funds. Projected funding for FY 2001 is $802,066 (state and federal).

c. Virginia did not receive Sudden Infant Death Syndrome funds; however, the Division of Women's and Infants' Health does provide information to families of SIDS infants.

6. SPECIAL CONSIDERATION FOR FUNDING PRE-1981 PROJECTS

Special projects existing prior to August 31, 1981 were the Maternal Infant Care (MIC) project at the Richmond City Health Department, two Children and Youth (C & Y) projects, one at the Norfolk City Health Department and the other at the University of Virginia, which also incorporated the "Dental Program Projects." The Neonatal Intensive Care Program was located at the Children's Hospital of the Kings' Daughters in Norfolk.

As a direct result of FY 81 Maternal and Child Health Block Grant reductions, funding to the C & Y at the University of Virginia was discontinued in FY 81. A method of distribution of these funds based on need has been adopted and implemented by the agency.

The Neonatal Intensive Care Program was continued but modified to reflect the provision of Perinatal Outreach Education. The recipient chose not to continue funding in FY 89. Funding was resumed in FY 92. Funding is currently provided to a total of seven Regional Perinatal Coordinating Councils to include professional outreach education.

The MIC project at the City of Richmond continues to be eligible for Title V funding based on the need for health services for pregnant women and infants.

7. REASONABLE PORTION OF FUNDS FOR SECTION 501 PURPOSES

Based on the State's previous use of funds under this title, a reasonable proportion of the allotted funds will be used to carry out the purposes of the Act described in Section 501(a)(1)(A) through (D).

Title V funds ($6,978,856) will be used for preventive and primary care services for pregnant women, non-pregnant women of child bearing age, mothers, infants, children and adolescents. These funds will be used for the following services: family planning services, local health department prenatal and child health services, genetic testing/counseling/ pharmacy and education, Regional Perinatal Coordinating Councils including professional outreach education, primary care initiatives, dental services, injury and violence prevention, and local programs to reduce infant mortality including the Resource Mothers Program and the Nutrition Intervention Project for Underweight Pregnant Women. These services serve the purposes outlined in Section 501(a)(1)(A) and (B).

Title V funds ($5,786,140) will be used to provide and promote family-centered community-based, coordinated care for children with special health care needs and the development of community-based systems of care for such children and their families. These services include specialized diagnostic, treatment, care coordination and follow-up services provided by children's specialty clinics and child development clinics. These services meet the purposes described in Section 501(a)(1)(C) and (D).

With regard to the purpose described in Section 501(a)(1)(C), the majority of SSI recipients under age 16 are receiving Medicaid services. According to the Social Security Administration, as of December 1999, there were 17,250 individuals under age 16 receiving SSI. Virginia's Medicaid Program is comprehensive. Among the varied health and medical care services provided by Medicaid to SSI recipients are the following: physician care, pharmacy, home health care, certain medical supplies and equipment, personal care, laboratory and x-ray services, outpatient care, respite care, unlimited hospital

stays when medically indicated, certain prostheses, physical therapy, and occupational therapy. SSI recipients to age 21 are eligible for services provided by the Children with Special Health Care Needs Program. In FY 99 340 program participants were recipients.

In addition to the services provided by the Departments of Health and Medical Assistance Services, services are also provided for SSI recipients under age 16 by the following agencies: Departments of Education, Social Services, Mental Health/Mental Retardation/Substance Abuse Services, Rehabilitative Services, Department for the Deaf and Hard of Hearing, and Department for the Visually Handicapped. The Department of Health is committed to serving SSI recipients under age 16 through services provided by the Children's Specialty Services Program, its participation in the Plan of Cooperation.

A collaborative relationship continues to exist between the Children's Specialty Services Program, the Social Security Administration Field Office in Virginia and Disability Determination Services in the Virginia Department of Rehabilitative Services to enhance each program's roles and responsibilities pertaining to the SSI beneficiaries.

8. REQUIREMENTS AND OTHER SOURCES OF FUNDS

The general funds targeted to support the match requirement are estimated at $11,598,037. These dollars dedicated as match for Title V exceed the 4:3 requirement by $2,024,289. Program income is estimated at $1,192,644. The total budget, including projected match, Title V funds, and program income is estimated to be $25,555,677.

Along with the $24,764,868 in Title V federal and state funds designated in Form 2, additional Federal funds are provided for maternal and child health services in Virginia. $3.8 million from Title X are planned for FY 01 to provide family planning services in local health departments. Other anticipated sources of MCH targeted funding include dollars for the Women, Infants, and Children (WIC) nutrition

program. The actual amount for FY 01 is unknown at this time; however, level funding is estimated to be $69.7 million. Additionally, estimated funds dedicated for childhood immunizations are $2.8 million; AIDS programs including surveillance and HIV testing, $5.6 million; fluoride/sealant for children, $63,503; injury prevention, $376,000; SSDI, $100,000; Behavioral Risk Factor Surveillance Systems, $107,704; Healthy Start, $2 million; Abstinence Education, $828,619; Childhood Lead Poisoning Prevention, $800,000, and Lead Abatement, $307,680.

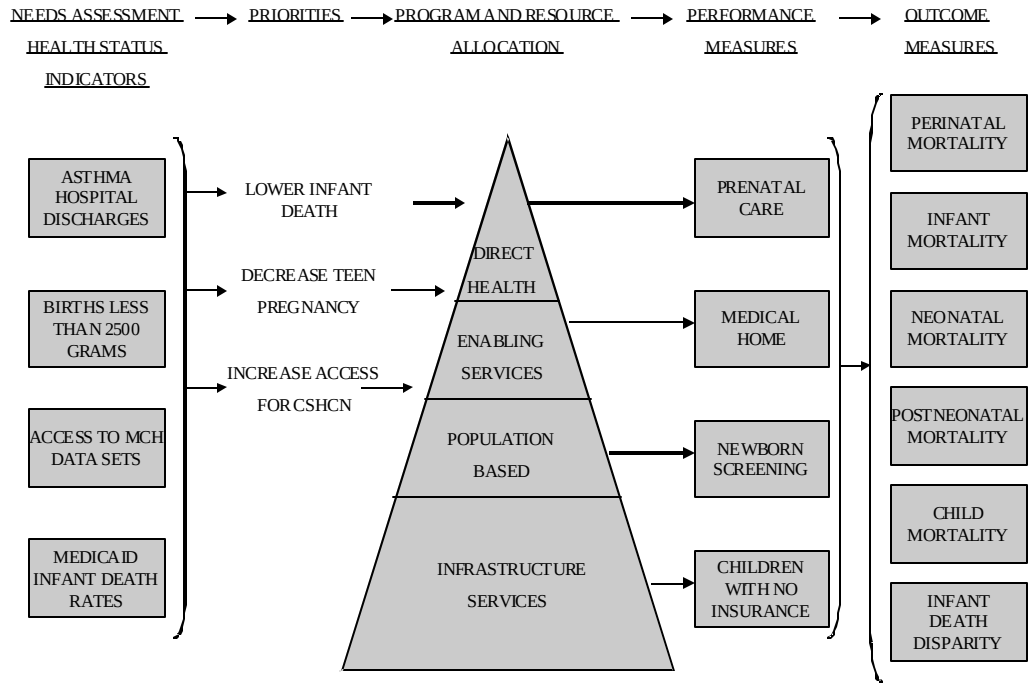
Besides the identified Federal-state partnership and other Federal funds targeted toward MCH populations, funding is received from the Department of Medical Assistance Services for Teen Pregnancy Prevention and Resource Mothers Programs. The Office of Family Health Services administers approximately $2 million. Also, $44.2 million in state and local funds and revenues are budgeted for statewide maternal and child health services, including family planning and dental health services.

9. UNOBLIGATED BALANCES

There are no known unobligated balances for the state fiscal year ending June 30, 2000 that are budgeted for the next state fiscal year 2001. Once the final balances are known, Virginia will provide a budget revision and identify the additional initiatives that will be funded with balances. The revision will identify initiatives and ensure the 30-30 requirement is met.

Figure 3

TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM



3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

Figure 4
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 14 and younger caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
SPM#1) Enhance statewide network of comprehensive, community-based health care for CSHCN. (FY 99 and FY 00)				X	X		
SPM#2) Percent of children and adolescents who have a specific source of ongoing primary care. (FY 99, FY 00 and FY 001)			X				X
SPM#3) The percent of health department patients of childbearing age who receive an annual pap smear. (FY 99 and FY 00)	X				X		
SPM#4) Number of calls received by the Virginia Fatherhood Campaign Resource Center. (FY 99 and FY 00)		X				X	
SPM#5) Percent of nonmarital births. (FY 99, FY 00, FY 01)			X				X
SPM#6) The rate of unintentional injury hospitalizations to children ages 1-14. (FY 99, FY 00, FY 01)			X				X
SPM#7) The rate of assault injury hospitalizations among youth aged 10 –19. (FY 99, FY 00, FY 01)			X				X
SPM#8) The rate of neural tube defects among live births. (FY 99, FY 00, FY 01)			X				X
SPM#9) Percent of children with a healthy weight (FY 99 and FY 00)			X				X
SPM#10) Percent of school districts that have completed a survey within the past five years to measure health-related behavior decisions by youth. (FY 01)				X		X	
SPM#11) Percent of newborns screened for genetic diseases and hearing loss who received recommended follow-up services. (FY 01)			X			X	
SPM#12) Percent of low birth weight infants for African Americans in perinatal under served areas. (FY 01)			X		X		
SPM#13) Percent of pregnant women in Virginia's perinatal under served areas receiving adequate prenatal care. (FY 01)			X		X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.1.1 Five Year Performance Objectives

(See Form 11, Section 5.8)

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

(See Section 5.10 for details on the State "Negotiated" Performance Measures)

3.4.2.2 Discussion of State Performance Measures

SPM#1: *Enhance the statewide network of comprehensive, community-based health care systems that serve children with special health care needs to assure family-centered, culturally competent, and coordinated services.* This performance measure addressed Priority # 1 to increase the availability and access to health care services in the FY 99 and FY 00 applications. This is an infrastructure building measure with activities that focus on an assessment of the CSHCN service delivery system and the implementation of recommendations for the future provision of health care services. This performance measure has been eliminated in the FY 01 plan. The study was completed and future activities relating to the implementation of the study recommendations can be captured by CPM# 2, CPM#3 and CPM#14 of the federal performance measures.

SPM#2: *The percent of children and adolescents who have a specific source of ongoing primary care for coordination of their preventive and episodic health care*. This is a population based performance measure that related to the FY 99 and FY 00 applications Priority # 1 to increase the availability and access to health care services. This is an important performance measure that will be useful to track the changes in the health care system resulting from the implementation of CMSIP and FAMIS. It will be continued in FY 01 to address Priority # 4 to improve access to health services and health insurance.

SPM# 3: *The percent of health department patients of childbearing age who receive an annual Pap smear.* This is a direct service measure that related to the FY 99 and FY 00 Priority # 7 to promote healthy behaviors. This performance measure was eliminated for FY 01. Clinic staff will continue to focus their efforts on early detection of cervical cancer as a standard of care.

SPM#4: *Number of calls received by the VDH Virginia Fatherhood Campaign Resource Center*. This performance measure specifically addressed FY 99 and FY 00 Priority # 6 to promote healthy families. This performance measure was eliminated for FY 01.

SPM# 5: *Percent of nonmarital births.* This performance measure was first established in the FY 99 application and remains in the FY 01 application. This performance measure was chosen because of the increasing proportion of nonmarital births in areas within the state and the potential negative health and social outcomes associated with the lack of father involvement within the family. OFHS remains concerned about changing family structure and its potential impact on health status. The Abstinence Education Initiative, the Partners in Prevention Initiative, the Teen Pregnancy Prevention Initiative and the Virginia Fatherhood Campaign as well as Resource Mothers and Healthy Start all support our focus on family structure and father involvement. This performance measure addresses FY 01 Priority #1 to improve health outcomes by strengthening families.

SPM# 6: *The rate of unintentional injury hospitalizations to children ages 1-14.* This performance measure is a population-based measure that relates to FY 01 Priority # 7 to promote health behaviors. This measure was continued from FY 99 and FY 00. The vast majority of injury hospitalizations result from unintentional injuries. There are major financial as well as physical costs related to injuries. For example, the injury hospitalizations resulted in charges of over 17.5 million dollars for children under 14 in Virginia in 1994. This performance measure was chosen because many unintentional injuries are preventable through such interventions as education, enactment and enforcement of legislation, engineering and environmental modifications.

SPM#7: *The rate of assault injury hospitalizations among youth aged 10-19.* This is a population-based performance measure that relates to FY 01 Priority # 7 to promote healthy behaviors. This performance measure was continued from FY 99 and FY 00 based on the needs assessment.

SPM#8: *Rate of neural tube birth defects among live births in Virginia*. This measure was first chosen for inclusion in the FY 99 application because neural tube birth defects are largely a preventable

condition through nutrition interventions. This is a population based performance measure with the focus on public education programs. The measure relates specifically to the FY 01 Priority # 7 to promote healthy behaviors. Pursuing activities related to this performance measure has potential to impact infant mortality, neonatal mortality, postneonatal mortality, and perinatal mortality.

SPM# 9 *Percent of children who have healthy weights.* This is a population based performance measure, but also includes infrastructure building activities. This measure was first included in the FY 99 application. Although activities will continue to address the issue of promoting healthy weight in children, the performance measure will not be included in the FY 01 application. Funding will be pursued to continue the periodic survey of 4th grade students and this measure will be included in future applications.

SPM#10: *Percent of school districts that have completed a survey within the past five years to measure health-related behavior decisions by youth.* Unlike many states, Virginia does not complete a statewide youth survey to identify youth behaviors. The information from these surveys is very important for the planning, implementing and evaluating programs for youth. Recent funding for the Right Choices Initiative in Virginia focusing on the promotion of positive youth behaviors makes the data from these surveys even more important. This is an infrastructure measurement that addresses FY 01 Priority # 7 to promote healthy behaviors.

SPM#11) *Percent of newborns screened for genetic diseases and hearing loss who received recommended follow-up services*. This is a population based performance measure. Virginia recognizes the importance of the newborn screenings including hearing screening. Virginia recently implemented universal hearing screening for all newborns. This measure recognizes the importance of not only identifying at-risk children, but also linking them with prevention and early intervention services. This measure addresses the FY 01 Priority # 5 to improve identification of "at risk" populations and assure linkage with prevention and early intervention.

SPM#12) *Percent of low birth weight infants for African Americans in perinatal under served areas*. The performance measure is new this year. The purpose in choosing this performance measure is to focus attention on the continuing racial disparity and to target the perinatal under served areas of the state. The measure addresses Priority # 4 and Priority # 6. It complements the existing efforts of the Virginia Healthy Start Initiative's focus on racial and ethnic disparities.

SPM#13) *Percent of pregnant women in Virginia's perinatal under served areas receiving adequate prenatal care*. The needs assessment shows the continuing issue of access to care in the perinatal under served areas of the state. The addition of this performance measure will enable us to monitor the impact of our efforts to increase access to care in these areas. The measure addresses Priority # 4 to increase access to health services and health insurance.

3.4.2.3 Five Year Performance Objectives

(See Form 11, Section 5.8)

3.4.2.4 Review of State Performance Measures

The state performance measures will be reviewed by the central and regional Maternal and Child Health Bureau staff and discussed with OFHS staff during the grant review process. Additional changes and clarifications may result. Each year the OFHS management team will review the core and the state performance measures as a part of the Title V planning process and the OFHS strategic planning process. The OFHS Family and Community Health Advisory Committee will also participate in the review of the performance measures.

3.4.3 Outcome Measures

(See Section 5.11 for details on Outcome Measures and Form 12 in Section 5.8 for Outcome Measure targets.)

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

4.1 Program Activities Related to Performance Measures

Activities that the Virginia's Title V Program will perform or participate in through sponsorship or support during FY 01 are designated below according to the level of services (direct medical care, enabling services, population-based services, and infrastructure building services), the target population groups (women and infants, children and adolescents, and children with special health care needs) and Virginia's identified priorities which include 1) improving health outcomes by strengthening families; 2) improving the quality of clinical, preventive and community-based services; 3) developing the capacity to meet customers' needs for accurate, reliable, timely and relevant public health information and assure its use in decision-making; 4) improving access to health services and health insurance; 5) improving identification of "at risk" populations and assure linkage with prevention and early intervention; 6) reducing minority disparities in health status; and 7) promoting healthy behaviors for children and women of childbearing age. The federally required core performance measures (CPM) and the state performance measures (SPM) that will be monitored to determine progress are also referenced in this section. Additional activities essential to the State's leadership role in maternal and child health care are also included.

4.1.1. Direct Services

In addressing the needs for direct health care services, OFHS has chosen to focus on the priorities of increasing access to health care services (State Priority # 4) and ensuring the quality of the services that are provided to the maternal and child population (State Priority # 2). Although there have been many

changes in Virginia's health care delivery systems over the past decade, there continues to be a need for a safety net of services to fill the gap in health care for many of Virginia's low income women, children, and the most vulnerable population, children with special health care needs. As in other states, Virginia's role in providing direct medical services will continue to shift as the health care delivery systems change as a result of the expansion of Medicaid managed care and the implementation of the new children's health insurance program (Title XXI). Thus the funding for the primary care support previously provided to the community health centers that have other federal support and expanded revenue potential was discontinued in FY 99, but the safety net funding for clinical services provided by the local health departments and through contracts with hospitals and other providers will continue. Infrastructure building will become increasingly important to provide assessment data and policies that support private/public collaboration to improve access to health care services and assure quality.

Over the past year there has been an increasing role for the Virginia Department of Health in assuring the quality of health care in the Commonwealth. During the next year, the OFHS Managed Care Team will continue to consider the Title V role in quality assurance external to VDH by working with the Office of Quality Health Care Services & Consumer Protection (OQHCS&CP) in the implementation of VDH's expanding quality assurance role resulting from recent legislative changes.

4.1.1.1 Women and Infants

The Maternal and Child Health Services Block Grant will continue to support family planning and prenatal services provided through clinics in local health departments. The family planning services will include the following: a complete medical history and physical assessment; routine laboratory testing; contraception including sterilization, Norplant and Depo-Provera; treatment of gynecologic problems including STDs and referral and follow-up for other identified problems; education and counseling; and pregnancy testing.

The Family Planning Program, in collaboration with the Fatherhood Program, is planning an educational and service effort to improve the utilization of the Sterilization Program by men. The Sterilization

Program has funds available each year for low-income individuals who otherwise have no available resources to pay for a voluntary sterilization. Most of the program users are women who are aware of the program through local health departments. The marketing program that has been developed will be implemented, making posters and pamphlets available to community health centers, free clinics, social service agencies and local health departments to advertise the benefits of sterilization to men and their families and how they can access the services. In addition, the local Fatherhood Programs will receive an educational presentation about the benefits of vasectomy and a review of the procedure. The men attending will have an opportunity to hear the vasectomy experience from a male who has had a vasectomy.

The Family Planning Program, working with the Virginia Sexual Assault Program and the Abstinence Education Program, will distribute two videos to staff who work with teens in various settings such as schools and health department clinics. One video will help staff to learn how to counsel teens to resist coercive sexual activity. The second video will help staff to implement abstinence as an option in a clinical setting such as a family planning clinic.

Prenatal services including pregnancy evaluation, risk assessment and intervention, psychosocial assessment and education will continue to be provided through the local health departments and specific arrangements with local hospitals, physicians, or clinics. The Maternal and Child Health Services Block Grant will continue to support the salaries of direct care personnel including physicians, public health nurses, health educators, social workers and outreach workers. Funding for laboratory and pharmacy costs including prenatal vitamins will continue. Nutrition services will be provided as an integrated part of prenatal clinics or in separate WIC clinics.

4.1.1.2 Children

All local health districts will continue to provide immunizations and school entrance exams as mandated by the *Code of Virginia*. Other services provided and the ages served will vary by district. Title V funds will support primary care services for children in those districts that identify this as a priority need

through a district application process. Most health districts will continue to provide some dental services for the low income population. Title V funds will purchase and distribute Bright Futures materials and other appropriate screening guidelines to local health departments and will provide on-site regional training on Bright Futures for local health department staff. In addition, Title V staff will implement and evaluate stand-up and web course training for health district staff and partners for incorporation of Bright Futures in Practice: Nutrition into program services to improve the use of anticipatory guidance relating to parenting and health. The Division of Dental Health will continue to provide on-site quality assurance for local health department dental programs.

4.1.1.3 Children with Special Health Care Needs

Children's Specialty Services (CSS) and Child Development Clinics (CDC) will continue for FY 01 as described in the Annual Report. As opportunities arise, the CSHCN Program will consolidate CSS contracts for direct services to integrate CSHCN Program services with other pediatric specialty services. VDH will maintain the memorandum of agreement with the Department of Mental Health, Mental Retardation and Substance Abuse Services for participation in the IDEA-Part C service system, to include coordination and utilization of available services for children birth to age three. No change is planned in the target for *CPM#2: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.*

An agreement with the Social Security Administration will be maintained to ensure that all SSI applicants are provided information about the CSS. All contracts for services to CSHCN will include the provision that all eligible patients be encouraged to enroll in SSI. These activities address *CPM#1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.* In FY 99 approximately 1.5 percent of the SSI beneficiaries less than 16 years old received services through the CSHCN Program. The 2001 objective is to maintain the FY 98 level of 3 percent.

4.1.2. Enabling Services

During FY 01, the OFHS will provide enabling services by focusing on increasing access to health care services (Priority # 4), especially for the most vulnerable populations such as pregnant teens and children with special health care needs, and improving health outcomes by strengthening families (Priority # 1). A major focus of the OFHS will continue to be placed on the role of fathers. OFHS recognizes that the health of women and infants is improved when men take responsibility for their sexual behavior and the children they conceive. In Virginia, the paradigm is shifting from a primary focus on women and children to a focus on the family including the father's role and responsibilities. To that end, Virginia created the first statewide Fatherhood Campaign and partnered with over 80 localities to reduce the out-of-wedlock births. Virginia's statewide abstinence initiative targeting youth 10 to 17 years will continue in FY 01.

4.1.2.1. Women and Infants

The division will continue to improve the quality and access to health services for women and infants in a variety of ways. Staff will identify published standards that will be adopted for use by division programs. The Resource Mothers Program Manager and the Healthy Start Project Director, in collaboration with DMAS, will conduct two regional forums for providers on the importance of early and adequate prenatal care, home visiting programs, and EPSDT. These staff will also work with DMAS, DSS, and HMOs to simplify the Medicaid application procedures to ensure timely care of pregnant women. Staff will also work with other staff within VDH to develop and market products to HMOs and assure testing and counseling of pregnant women with HIV to prevent perinatal transmissions.

It is also planned that Baby Care staff and Resource Mothers receive information and training about providing outreach, collaboration with other providers and home-based services for diverse cultural groups each year.

A Basic Breastfeeding Curriculum has been developed which targets standards of care for hospital personnel. Regional train-the-trainer sessions are planned throughout Virginia this summer that the State Task Force will monitor and evaluate.

Future efforts include a workshop presentation on shared care and how it can be profitable. Virginia Chapter ACNM and Virginia Academy of Family Physicians representatives will deliver this workshop at the annual meeting of family physicians.

4.1.2.2 Children

Comprehensive Health Investment Projects (CHIP) will be funded in those health districts that identify this as a priority need through a district application process. CHIP provides medical/social case management for families with children aged 0 to 6 years in low-income families.

The Resource Mothers Program will continue to provide lay home visiting services to pregnant and parenting teens in 80 localities. The 28 program sites will provide home visiting services to encourage teens to keep medical appointments and to avoid harmful behaviors such as smoking and alcohol consumption. Follow-up for a year will help these young women delay subsequent pregnancies. Additional funding from Healthy Start is enabling targeted programs to expand services to include the 20-24 year old women. In conjunction with the Virginia Fatherhood Campaign, the Resource Mothers Program strives to promote father presence in the pregnancy and improve the quality of fathering. Resource Mothers addresses *CPM# 15 and 18*.

CHIP, Baby Care, and Resource Mothers are Title V enabling services to ensure that children have a primary care provider. In addition, Title V will help fund direct primary care services in those health

districts that identify this as a priority need through a district application process. These activities address SPM#2: *The percent of children and adolescents who have a specific source of ongoing primary care for coordination of their preventive and episodic health care.* The 1999 Virginia Children's Health Access Survey found 75 percent of children to have a medical home. Title V funds will support a repeat survey in FY 01 to measure progress on this objective.

Completed immunizations is another objective of the CHIP and Resource Mothers Programs. These activities address *CPM#5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.*

4.1.2.3 Children with Special Health Care Needs

During the year the CSHCN Program will move incrementally to expand enabling services beyond CSS program participants. As opportunities arise, the CSHCN Program will contract with regional entities to provide resource and referral information and advocacy support for all families to facilitate appropriate utilization of resources. These activities support *CPM#3: The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."*

4.1.3 Population Based

During FY 01 many of the Title V population-based activities will focus on prevention. These activities will include improving systems to identify at-risk children and link them with appropriate prevention and early intervention services (Priority # 5), encouraging healthy behavior for children and women of childbearing age (Priority # 7), and making sure that all children have access to preventive health care services (Priority # 4). In addition, OFHS will focus efforts on decreasing the racial disparity in the health status of the MCH population (Priority # 6).

4.1.3.1 Women and Infants

All newborn infants in Virginia will continue to be screened for six metabolic conditions and sickle cell disease. The goal in FY 01 is to ensure that all confirmed positive newborn-screening tests will be followed by appropriate treatment. (See Form 6 for specific screening data related to *CPM#4: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies, e.g., the sickle cell disease)*. The target is 100 percent of all newborn infants will be screened. Funding will also continue to support the food/formula products for children with in-born errors of metabolism.

HB 542, passed in the 2000 General Assembly, requires that VDH provide low protein *food* products for children with PKU. It allows the parents or a guardian of a child affected by PKU to receive reimbursement from the Department for the cost of such special solid foods in excess of two percent of their gross income, in an amount not to exceed $2000 per diagnosed person per year. Currently Virginia's PKU program only supplies parents with the *liquid formulas* to medically indigent families. The bill also requires VDH to provide special food products, including both liquid formulas and solid foods, to pregnant women with PKU.

In addition to this, the Genetics Program will implement another bill that requires OFHS to complete a study on the feasibility of screening for congenital adrenal hyperplasia. The Newborn Screening Subcommittee of the Genetic Advisory Board to VDH met to discuss the addition and/or deletion of tests to the newborn screening program. In 1999, the addition of congenital adrenal hyperplasia (CAH) to the current battery of tests was discussed and a study of the issue was initiated. Though this newborn screening test has already been examined and plans are already underway to consider adding this test, the bill may raise the level of public awareness about this public health issue, and allow the legislature to fully examine the costs and benefits of conducting this test. Legislation will be necessary to make CAH

part of the newborn screening battery of tests. VDH and the Department of Consolidated Laboratory Services will be ready to consider this legislation next year.

The Genetics Program Manager will prepare a five year aggregate report on birth defects for hospitals, local health departments, RPCs, physician and nursing organizations this year.

Up to 70 percent of neural tube defects can be prevented through folic acid supplements of Many of the neural tube related birth defects are preventable through good nutrition practices by women. Promoting the role of folic acid in the prevention of neural tube birth defects will continue as a program emphasis. VDH will continue to collaborate with the March of Dimes, Virginia Chapter, to implement a grant from the National March of Dimes for the radio education campaign in Virginia. The radio ads will be aired again in August 2000. The radio campaign is currently being evaluated by the Southeastern Institute of Research. VDH and the March of Dimes, Virginia Chapter will continue to manage the administration of the Virginia Council on Folic Acid through facilitation of meetings and distribution of the minutes and other correspondence. In addition, VDH will distribute the March of Dimes folic acid flyer to marriage license offices in Virginia. This action is being taken as part of the SB 1280 legislation passed in the Virginia General Assembly in 1999. The VDH brochure in English and Spanish may be considered for distribution in FY 01 if funds are appropriated. These activities address SPM #8: *Rate of neural tube birth defects among live births in Virginia.*

In 1998, 60.3 percent of Virginia mothers were breastfeeding their infants at time of hospital discharge. This fell below the National Healthy Objective of having 75 percent of newborn infants' breastfeeding. The following breastfeeding promotion activities are planned to create a positive environment for breastfeeding families: a basic lactation training program for interested hospitals, model standards for workplace lactation support, Mom and Baby Station at the Virginia State Fair, and continued outreach through breastfeeding educational and promotional materials. The State Breastfeeding Task Force will lead a meeting with maternal and infant programs, including hospitals and Regional Perinatal Councils, to collaborate on a women and children's health fair during the Year 2000. The American Academy of Pediatrics designated breastfeeding coordinator for Virginia, Dr. Jim Ogan, is a member of the Task

Force and has planned activities to educate physicians and develop promotion strategies with neighboring states. A basic Breastfeeding curriculum which targets standards of care for hospital personnel. Regional train-the-trainer sessions are planned throughout Virginia this summer that the State Task Force will monitor and evaluate. These activities address *CPM#9 Percentage of Women Breastfeeding*.

As an abstinence-based program that promotes healthy families through marriage, Partners in Prevention (PIP) has had the opportunity to network with the Virginia Abstinence Education Initiative and the Virginia Fatherhood Initiative. Joint seminars and marketing material with messages that promote waiting until marriage to conceive a child, abstinence until marriage, and fatherhood has been developed for FY 00 and FY 01. These activities address *SPM #5: Percent of nonmarital births*. The percent of non-marital births to total live births was 29.3 percent in 1997 and was 29.8 percent in 1998. The rise in nonmarital births in Virginia indicates a need to increase the effort of PIP. With funding for PIP having been provided through TANF, the nonmarital birth rate projection for 2000 is decreased. Resource Mothers also seeks to decrease repeat nonmarital births.

Program managers in the division will implement educational strategies on abstinence and responsible sexual behavior, sterilization, fatherhood promotion, smoking cessation, perinatal substance abuse cessation, and birth defects prevention. These efforts will go hand in hand with a new Web site that will make information and resources on Title V-funded services available to a broader audience.

Staff will collaborate with the Center for Sustainable Health Outreach to develop training curriculum on healthy behaviors for community health workers in Resource Mothers, Project Link, and Community Health Centers.

The division will continue efforts to reduce racial and ethnic disparities in health status among pregnant women and infants. Program managers will develop a district profile using current and relevant health statistics on women's and infants' health, including racial and ethnic differences. Two new performance measures will be used: *SPM#12: Percent of low birth weight infants for African Americans in*

perinatal underserved areas, and SPM# 13: Percentage of women in Virginia's perinatal underserved areas receiving adequate prenatal care. In addition, Healthy Start staff will conduct client satisfaction surveys within VHSI programs.

4.1.3.2 Children

The Title V program will continue to provide staff and resources to prevent teen pregnancies. FY 01 activities will include guidance and monitoring of the Teenage Pregnancy Prevention Initiatives, funded through the Medicaid program, in seven health districts: Richmond City, Alexandria, Norfolk, Roanoke City, Portsmouth, Crater, and Eastern Shore. Staff will continue to collaborate with the VDH Office of Health Policy on the Teen Pregnancy Prevention Initiative evaluation. In addition, the Title V program will fund, guide, monitor, and train Better Beginnings Coalitions in 19 communities to increase awareness and develop community approaches to the prevention of teen pregnancy through youth development, media, and other activities. These activities address *CPM#6: The rate of births (per 1,000) for teenagers aged 15-17 years.* The FY 01 objective is 21 births per 1,000 teens.

CPM#7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth. In FY 01 the Division of Dental Health will develop a guidance manual for local health department dental programs and others regarding dental health education. They will provide training to Head Start and Department of Education staff. Title V funds will continue to provide materials for 45,000 children to participate in the school-based fluoride mouthrinse program in 49 counties that do not have access to community fluoridation. Participants will be converted to pre-mixed fluoride to increase compliance and reduce risk. The program will be expanded to 3,000 additional children in two new communities and participation increased in two counties.

SPM#6: The unintentional injury hospitalization rate for children ages 1-14 per 100,000. The VDH Center for Injury and Violence Prevention will continue to promote child safety through public information, training and community education, community events, coalitions, and a media awareness campaign. The Center will distribute information and materials through its website and resource center.

Unintentional injury programs will target home, recreation, workplace, and transportation safety and target child care providers, school personnel, and health care providers. Infrastructure building activities during FY 01 will include training for childcare providers, participation in a review of childcare safety regulations, and information, training, and resources to support adoption of Risk Watch and other injury prevention curricula by schools. The Center will transfer leadership of Virginia's participation in the National SAFE KIDS campaign to another public or private organization that can coordinate a highly visible campaign in media, marketing, community event coordination, and policy activities.

The Center's child passenger safety program will continue to be funded by the Department of Motor Vehicles from a federal highway safety grant. *CPM#8: The rate of deaths to children aged 14 and younger caused by motor vehicle crashes per 100,000 children*.

SPM#7: The incidence of assault injury hospitalizations among people aged 10-19. The Center for Injury and Violence Prevention will develop a youth violence prevention program in FY 01. The program will provide information on youth violence prevention through brochures, tip sheets, and presentations for parents, pastors, public school teachers, health care providers, and youth. Staff will collaborate with the Department of Education to provide schools with training and encourage adoption of the GET REAL ABOUT VIOLENCE and other violence prevention curricula.

The Title V program will collaborate with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Commission on Youth in a new suicide prevention initiative instituted by the 2000 General Assembly. VDH will focus on adolescent suicide prevention through education and training in the first year of the initiative. The Center for Injury and Violence Prevention will issue an RFP for five crisis centers in the state to train staff and community leaders on suicide prevention. The program will contract with an outside organization to provide training for guidance counselors, teachers, social workers, counseling therapists, and ministers to learn to identify and refer youth at risk of suicide. Training will also be offered for electronic and print media reporters and editors on the CDC Guidelines for *Reporting on Suicides*. Instructional materials on suicide prevention will be purchased and

distributed, possibly through the crisis centers. These activities support *CPM#16: The rate (per 100,000) of suicide deaths among youths 15-19.*

The Virginia Fatherhood Campaign will continue to promote programs and policies that support father-presence in the lives of their children and improve the quality of fathering. The FY 01 Campaign will emphasize outreach through the faith community, correction centers, and barbershops and will promote the benefits of marriage. The program will develop two new brochures, "Men and Marriage" and "Fatherhood Behind Bars." Other activities will include continuation of approximately 20 seed grants from Title V and TANF funds to support community projects, a statewide skills-building conference, the Resource Center for literature and consultation, and a media campaign to include bill boards, radio PSAs, digital PSAs, and transit signs. These activities support SPM*#5: Percent of nonmarital (father absent) births.*

4.1.3.2 Children with Special Health Care Needs

The *Code of Virginia* provides for all infants born in hospitals to receive a hearing screening test effective July 1, 2000. During FY 01, the Virginia Hearing Impairment Identification and Monitoring System (VAHIIMS) program staff will continue to work with hospitals and licensed audiologists and facilities providing follow-up regarding the protocols and new reporting requirements. Hospitals will be encouraged to develop community partnerships to establish and/or strengthen their screening and follow-up programs. VAHIIMS staff, in collaboration with the Part C Early Intervention program, will offer training on early intervention for children with hearing loss to providers of intervention services. Staff will offer consultation and technical assistance for efforts to assure third-party coverage for newborn screening and follow-up. Other activities will include educating parents, the medical community, and the general public regarding the importance of early identification and appropriate follow-up of hearing loss. In addition, staff will continue working with the MCHIP grant project, now with the National Center for Hearing Assessment and Management of Utah State University, for the implementation of universal newborn hearing screening. These activities address *CPM#10: Percentage*

of newborns who have been screened for hearing impairment before hospital discharge. The FY 01 objective for this measure is 95 percent.

The Title V program will continue to administer the Virginia Congenital Anomalies Reporting and Education System (VaCARES), a statewide birth defects registry established by the *Code of Virginia*. In addition to collecting data, VaCARES will inform parents and physicians about available resources.

OFHS hopes to integrate the computer registries for hearing impairment (VAHIIMS), congenital anomalies (VaCARES), the Newborn Screening Program, and Part C Child Find in FY 01. In addition, OFHS plans to integrate the program functions and budget within the CSHCN program. The effectiveness of this transition in conjunction with implementation of universal newborn hearing screening will be monitored by a new State performance measure, *SPM# 11: Percent of infants screened for genetic diseases and hearing loss who receive recommended follow-up services.*

4.1.4. Infrastructure

With the rapidly changing health care delivery system there is an emerging importance on the infrastructure building activities within the OFHS. Changes related to welfare reform, the implementation of Medicaid Managed Care and the new children's health insurance program (Title XXI) require that the OFHS focus even more on assessment, policy development, and quality assurance. The ready availability of quality public health data is crucial to provide a basis for policy development, quality assurance, and program monitoring. The development and improvement of information systems and analytic skills of staff will continue to be an important focus. The activities will address all of the OFHS identified priorities.

4.1.4.1 Women and Infants

The OFHS Division of Women's and Infants' Health will continue to provide policy and procedural oversight concerning women's and infants' health services. This will include the monitoring of data related to low birth weights, infant mortality, women's and infants' health issues, and access to prenatal care. The racial disparity in these data will also be monitored.

The Healthy Start, Resource Mothers and Perinatal Nurse Consultant will integrate the perinatal data collection systems from Healthy Start into VISION, a new integrated data system at VDH.

Funding for the seven Regional Perinatal Councils (RPCs) will continue during FY 01. The RPCs will continue to focus on development and maintenance of the community level infrastructure necessary to support the delivery of perinatal services. The RPCs will continue to implement the Fetal Infant Mortality Reviews (FIMR) and address issues related to low birth weight infants, access to care, and infant mortality. The emphasis of the FIMR is to gather data that will provide a basis for system changes. The RPCs' activities will include a focus on the racial disparity in low weight births and infant mortality and an analysis of system changes to address the disparity. RPCs participated in the development of Virginia's Healthy Start Grant and they serve as the State Healthy Start Consortium. The FIMR projects will be continued with Healthy Start funding. The RPCs' activities address *CPM#15: Percent of very low birth weight live births; CPM#17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates; and CPM#18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

OFHS recently applied for technical assistance from the AMCHP Data and Assessment Technical Assistance Program. The technical assistance requested would enable OFHS to explore the potential for developing a PRAMS or PRAMS–like surveillance system. The implementation of this system would enable OFHS to better plan interventions, develop policies and evaluate the effectiveness of programs and services addressing the needs of pregnant women.

Title V funds will continue to partially support the Child Fatality Review Team located in the Office of the Chief Medical Examiner (OCME). A team consisting of staff from the OFHS, OSME, and the RPCs will review the roles of all four of Virginia's maternal and child mortality related teams (FIMR, Child Fatality Review, SIDS, and Maternal Mortality Review) and develop a plan to coordinate and/or consolidate the review processes. The team identified the need to create mechanisms to integrate these programs into a collaborative network in order to identify mutual areas of concern, to increase efficiency, and to utilize review findings for assessment, policy development, and prevention. VDH was awarded an MCHIP grant under the Child Mortality/Morbidity Review Support Program to help address this need. In the upcoming year the team will develop recommendations that may include regular meetings, policy and practice changes, increased representation of staff working in the programs, and the development and dissemination of reports to share what has been learned.

The Division will continue to work with representatives of provider organizations serving pregnant women and infants increase access to care and the quality of care to poor, pregnant women, particularly those in perinatal under served areas.

In the area of genetics, OFHS will be developing a plan to move the genetics program to the Division of Child and Adolescent Health within the next year, so newborn screening services can be consolidated and program efficiencies can be achieved.

The Women's Health Task Team will conduct a survey to document the existing women's health programs in VDH. They will also conduct an assessment of the existing data systems to determine where women's health data needs improving. The task team will also identify funding opportunities to address women's health issues.

In August 1999, staff from the OFHS began informal discussions with staff from DMAS on several issues regarding entry into prenatal care, children with special care needs and the impact of the Medicaid managed care on health care for pregnant women and children. The Prenatal, Infant, Children and Special Needs Committee (PICS) was formed to meet regularly to address these issues. This

committee serves as the forum to develop the update of the interagency agreement. The committee will also be discussing the barriers to prenatal and CSHCN services and implement identified solutions as possible.

4.1.4.2 Children

The Division of Child and Adolescent Health (DCAH) will continue to provide leadership in planning, developing, and implementing efforts to improve the health of children and adolescents in Virginia. In addition to Title V block grant services, DCAH oversees the abstinence education, lead poisoning prevention, and Healthy Child Care America grant programs as well as contracts with the Department of Social Services for health and safety in child care, fatherhood initiatives, and abstinence education initiatives. The Division of Chronic Disease Prevention/Nutrition will continue to provide consultation and technical assistance on child and adolescent nutrition and health. The Division of Dental Health will continue to provide leadership in planning and implementing efforts to improve the oral health of children and adolescents. The Center for Injury and Violence Prevention will continue to provide leadership for childhood injury prevention strategies. The Center oversees the child transportation safety, sexual assault prevention, and fire safety grant programs. OFHS has established task teams to coordinate activities for the early childhood and the school-age populations.

DCAH will collaborate with the Department of Medical Assistance Services (DMAS), child care providers, school health personnel, and the WIC Program to implement statewide outreach strategies for the new Family Access to Medical Insurance Plan (FAMIS). DCAH will offer consultation and technical assistance to the DMAS for monitoring and evaluation of FAMIS, building on the current partnership to monitor *CPM#12: Percent of children without health insurance*. In 1999, 90 percent of children had some form of insurance. A repeat children's health access survey is planned for FY 01 to monitor this objective. Statewide outreach strategies for FAMIS will increase Medicaid enrollment as well. *CPM#13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program.*

In collaboration with the Department of Education, DCAH will continue to provide training and develop/update resources for school health personnel. Activities for FY 01 include: (1) convening three statewide meetings of School Nurse Coordinators/Contact Persons to provide updates and educational activities; (2) convening three meetings of the School Nurse Institute Partnership to support statewide coordinated school health services educational activities and strengthen competencies in school nurse curricula; (3) developing a school unlicensed assistive personnel medication training manual; (4) developing the School Health Advisory Boards Summary Report for School Year 1999-2000; (5) providing consultation and technical assistance for state- and local-level policymakers and providers for coordinated school health programs, including School/Community Health Services Grants and School Nursing Incentive Fund; and (6) providing regional training on health and learning for school superintendents, school board members, and School Health Advisory Boards. Title V staff will work with the Department of Social Services and others to develop a health screening form for preschoolers.

The Title V program will be an active partner in the Governor's Right Choices for Youth initiative. To help measure the effectiveness of this initiative, the Title V program will work with the Right Choices Committee and the Department of Education and/or a research organization to implement the Youth Risk Behavior Survey or a similar survey. Progress will be measured by a new State performance measure, *SP# 10: Percent of school districts that have completed a survey within the past five years to measure health-related behavior decisions by youth.*

The top priority goal for DCAH in FY 01 is to develop the capacity to meet customers' needs for accurate, reliable, timely and relevant public health information and assure its use for decision-making (Priority # 3). DCAH will recruit an epidemiologist/data system specialist to lead, manage, and carry out child health assessment activities. This position will collaborate with others to develop an information management framework for collecting, analyzing, disseminating, and utilizing child and adolescent health data. One component may be the standardized data collection, analysis and reporting mechanism, currently under development by the Center for Pediatric Research, Eastern Virginia Medical School, to measure the ongoing quality and cost of pediatric health care in the Commonwealth. OFHS staff will continue to provide consultation and technical assistance to local health departments

and other public/private agencies for obtaining, analyzing, and using child health data. An additional statistical analyst position funded by the State Systems Develop Initiative (SSDI) is currently being recruited. This position will provide additional resources to monitor core and state performance measures.

In FY 01 CIVP will develop an interactive morbidity and mortality data access on its web site. They will collaborate with Virginia Health Information, the Virginia Health and Hospital Association, or other organizations to provide E-code training for hospital coders and others.

The State Child Fatality Review Team will complete a review of all deaths among children four years of age and younger. The review will focus on the quality of infant death investigations and the completeness of toxicology and radiographs for infant autopsies, as well as other issues that may arise out of the review.

4.1.4.3 Children with Special Health Care Needs

The Division of Child and Adolescent Health will continue to provide leadership in planning, developing, and implementing efforts to improve services for children with special health care needs (CSHCN) in Virginia.

During FY 01 OFHS will make incremental changes in the CSHCN Program to consolidate contracts and develop more comprehensive services that include family-to-family support, enabling services, direct specialty care, information and referral, and linkage to services. These changes will address some of the recommendations from the study *Services for Children with Special Health Care Needs and Their Families: Virginia 1999 Needs Assessment and Recommendations*. Title V staff will continue to serve on the Monitoring and Improvement Measurement System task force of Part C-IDEA/Babies Can't Wait to implement a statewide self-evaluation system to ensure that services are met for infants and toddlers with disabilities. Title V program staff also will serve on the state-level Continuous Quality Improvement\Ability to Pay committee for Part C-IDEA. In FY 01 the committee will examine

strategies to enhance and integrate approaches on ability to pay/fees for services. These activities will support *CPM#11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.*

Family representatives will continue to serve on the VAHIIMS and the Hemophilia Advisory Boards. Family representative(s) will be added to the Advisory Board for Genetics, Metabolic, Endocrine and other Inherited Disorders. *CPM#14*: *The degree to which the State assures family participation in program and policy activities in the State CSHCN program.*

Child Development Clinic staff will continue to provide ongoing training and technical assistance to primary pediatric health care providers, public health nurses, child care providers, school staff, and others in developmental screening and care planning. They will also provide consultation to community Head Start programs, participate on the local and/or state Head Start Councils, and provide program training and technical assistance to early childhood development programs.

4.1.4.4 General Infrastructure Building Activities

The Title V program will continue several infrastructure building activities that support the health of the MCH population in general. Title V will continue to support the analysis and reporting of marriage and divorce data, an important data source related to the health and welfare of Virginia's children. In FY 01 plans include (1) a review of Virginia data related to the status of families in Virginia and the impact on health; (2) identification of successful models/strategies that promote healthy families; (3) development of an implementation strategy for Virginia to promote healthy marriages, healthy families and healthy relationships.

In FY 01, the Managed Care Policy Analyst will continue to provide leadership to the Managed Care Team and the OFHS managed care role. During this year, the team will collaborate with the Center for Quality Health Care Services and Consumer Protection (CQHCS&CP) in the quality assurance certification for managed care organizations efforts (SB 712 – 1998 General Assembly). The

Managed Care Task Team will provide policy development expertise and input to the DMAS in the development and review of the Medicaid state plan and managed care contracts. In addition, the team will assess the current involvement of managed care plans in clinical and community prevention services and identify opportunities for public health collaboration. The Managed Care Team will seek opportunities to educate public health agencies in how to adapt to the changing health care environment that has resulted from the expansion of managed care. This will include seeking technical assistance from the newly established HRSA Managed Care Technical Assistance Center (MCTAC). The Managed Care Policy Analyst will work with the OFHS divisions to identify and market products and services to the managed care organizations. She will also continue to review all managed care related legislation during the 2001 General Assembly session.

To facilitate the work of the Secretary of Health and Human Resources, the Title V program will continue to be available to provide staff support for the Maternal and Child Health Council and its subcommittees although the Council has not been convened since 1998. Title V staff will continue to provide analysis and recommendations to the Governor on legislation before the General Assembly that will directly affect VDH programs and women's and children's health in Virginia. They will continue to review and comment on legislation, regulations, and standards of other state agencies from a maternal and child health perspective.

The MultiCultural Health Task Force (MCHTF), which consists of representatives from OFHS, the Office of Health Policy, the Office of Minority Health, Primary Care, and Refugee Health, was established to focus on the assessment of health status and health service needs of the different cultural groups within Virginia. During FY 99, the MCHTF developed and administered a survey to identify and describe some of the successes, best practices and problems that public health providers encountered when delivering services to multicultural populations. From this research the MCHTF developed a series of recommendations to improve services for these populations. These included the need to establish links, educate and communicate with relevant community-based networks, religious organizations, and local leaders. Phase II of the project included focus groups conducted with a number of different cultural groups across the state to identify their perceived barriers to health care

services and recommendations for improvement. A report summarizing the focus group findings will be completed this year. The MCHTF is currently planning to expand the membership to include representatives from other state agencies and other HRSA funded programs. Goals of the expanded task force are to increase collaboration among agencies/organizations serving multicultural communities and to jointly develop a research agenda to address racial disparity and provide understanding of the contributors to the disparity.

Assessment as a core public health function continues to receive greater recognition in the OFHS. During the next year, OFHS will continue to seek staff training opportunities related to assessment. Three OFHS staff members recently participated in the analytical training offered through the University of North Carolina at Chapel Hill. The training, Enhancing Data Utilization Skills Through Information Technology (EDUSIT), is distance-based learning and is funded by a grant from the Maternal and Child Health Bureau. Kimberly Carswell, the Senior Statistical Analyst in the Policy and Assessment Unit, will continue to serve as the Association of Maternal and Child Health Programs (AMCHP) state MCH data contact and participate in the related training opportunities offered at the annual AMCHP meeting. Cecilia Barbosa, Director of the Division of Child and Adolescent Health, continues to serve as an alternate state member on the AMCHP Data and Assessment Committee. OFHS staff will continue to look for opportunities to present program and research findings at various national meetings such as APHA and AMCHP.

4.2 Other Program Activities

Title V and XIX Interagency Agreements

An interagency agreement exists between the Departments of Health and Medical Assistance Services for the coordination of Titles V and XIX services. The assignments of responsibilities as stated in the agreement are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory function and mission of the Department of Health. A copy of the agreement may be found in

the Appendix. The agreement has not recently been updated, however a VDH/DMAS task team has been established to review and amend the agreement. New sections will most likely include such issues as data sharing, increasing the reimbursement rates for Baby Care and the new children's health insurance program (FAMIS).

DMAS directs the EPSDT Program and collaborates with the VDH and DSS on specific components of the program. VDH interagency responsibilities include, when appropriate (1) providing consultation on developing subsystem and data collection modifications, and (2) collaborating on (a) modifying the Virginia EPSDT Periodicity, (b) developing screening standards and procedure guidelines for EPSDT providers, (c) developing materials to be included in the EPSDT Supplemental Medicaid Manual and other provider notices as may be required, (d) providing EPSDT educational activities targeted to local health departments, (e) implementing strategies that will increase the number of EPSDT screenings, (f) making available current EPSDT program information brochures and other materials that are needed to communicate information to local health department patients, and (g) participating on the DMAS-reconvened Virginia Maternal and child Health Workgroup to ensure communication and collaboration among its members.

In 1987 the Department of Medical Assistance Services, with the Departments of Health and Social Services, developed a plan for care coordination and other expanded services called Baby Care. The program services include outreach and care coordination for high-risk pregnant women and infants, education, counseling on nutrition, parenting and smoking cessation and follow-up and monitoring. The responsibility for the administration of Baby Care is a collaborative effort among three state agencies, i.e., the Department of Medical Assistance Services, the Department of Health, the Department of Social Services and managed care organizations.

The interagency agreement also includes coordination of Medicaid and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The agreement includes mechanisms to assist eligible women and infants to obtain Medicaid coverage and WIC benefits. In addition, the Maternal Outreach Program - a cooperative agreement which expands the VDH Resource Mothers

Program - supports the coordination of care and services available under Title V and Title XIX by the identification of pregnant teenagers who are eligible for Medicaid and assisting them with their eligibility applications.

The Virginia Department of Health and the Department of Medical Assistance Services also have an agreement related to the Teenage Pregnancy Prevention Program. According to the agreement, the Department of Medical Assistance Services provides funding to the Department of Health for the costs of local teen pregnancy prevention programs. The Department of Health monitors the programs.

The MCH Help Line

During 1995 the OFHS evaluated the current MCH Help Line agreement with the Department of Medical Assistance Services and decided to seek information and referral services from a source more equipped to meet the needs of the maternal and child population. After evaluating a number of existing toll-free help lines, the Office of Family Health Services entered into an agreement with the Department of Social Services' Statewide Human Services Information and Referral System. The Memorandum of Agreement became effective July 1, 1996. The agreement with the Department of Social Services describes the plan for interagency administration, coordination, and financing and arrangements for collecting and updating provider data. Data documenting maternal and child health related service calls is collected and reported to the OFHS quarterly as a condition of the agreement. This information provides data for future needs assessments and program planning. A copy of the most recent agreement is included in the Appendix.

During the first year of the contract, OFHS and the Department of Social Services focused their efforts on identifying community referral resources, identifying reporting data, and marketing the Help Line. During FY 97, a poster marketing the Help Line was developed and distributed to approximately four hundred agencies serving women, teens and children. In FY 98, a brochure was developed and was distributed to local health department staff and grant recipients serving the MCH population. The Department of Social Services purchased and distributed additional copies of the MCH poster and

brochures to child care centers during FY 99. FY 01 plans include further refinement of the data reporting requirements and training for the I & R staff on appropriate referrals to meet the needs of the MCH population.

The Statewide Human Services Information and Referral System is a state administered system with six regional sites across the state. The toll-free number is 1-800-230-6977. The system has been helping Virginians since 1974. During FY 99, 18,278 calls identified as MCH calls were received. This number also serves as the state number for the National Baby Line to provide information and referral for prenatal care.

Children with Special Health Care Needs

The Division of Child and Adolescent Health's Children's Specialty Services (CSS) and the Child Development Clinic Services (CDC) programs have provider agreements with the Department of Medical Assistance Services. Copies of these agreements are on file in the Office of Family Health Services and are reviewed periodically. The CSS and CDC programs bill Medicaid for pharmacy, physician, laboratory, and hearing services.

A collaborative relationship has also been established between the Children's Specialty Services Program, the Social Security Administration Field Office in Virginia and the Disability Determination Services in the Virginia Department of Rehabilitative Services to enhance each program's roles and responsibilities pertaining to the SSI beneficiaries. Strategies for publicizing each program, facilitating application for benefits and services, expediting referrals, acquisition of medical and other evidence, and reciprocal training about programs available to children with disabilities are continuing.

Other Collaborative Agreements

The Commissioner of the Department of Health serves on the Early Intervention Agencies Committee which was established in 1992 through Section 2.1-760-768 of the *Code of Virginia* to ensure the

implementation of a comprehensive system of early intervention services for infants and toddlers. A representative from the DCAH is an active participant on the Virginia Interagency Coordinating Council (VICC) and the Part H/C Interagency Management Team. At the local level, professional staff from the health departments and the Child Development Clinics serve on the local interagency coordinating councils.

The Comprehensive Services Act for At-Risk Youth and Families provides a comprehensive, coordinated, family-focused, child-centered, and community-based service system for emotionally and/or behaviorally disturbed youth and their families throughout Virginia. A representative from the DCAH serves on the State Management Team and representatives from the state and local health departments serve on workgroups. All local health departments and/or Child Development Clinics serve on local community policy and management teams and family assessment and planning teams.

The Title V funded programs are also coordinated with other health department programs which serve a common population group including Immunization, STD/AIDS, and Dental Health programs. Immunizations are provided as part of local health department family planning and well-child services. Screening and treatment for STDs are provided in family planning clinics. Family planning, prenatal, and well child patients may be referred to health department dental services.

Copies of all interagency agreements are maintained on file in the Office of Family Health Services and are reviewed annually and amended as required.

4.3 Public Input [Section 505(a)(5)(F)]

This application has been made public in accordance with the Commonwealth's usual practices. The draft FY 01 Title V application was made available to the 35 district health departments and other interested parties. The draft document was made available to the public through the placement on the OFHS website (www.vahealth.org). The OFHS Family and Community Health Advisory Committee provided input into the development of the FY 01 application and was provided an opportunity to review and comment on the draft FY 01 application. The Committee represents various regions

within the state and organizations representing the MCH target populations. The OFHS also will seek opportunities during FY 01 to present an overview of Virginia's Maternal and Child Health programs funded by Title V at various meetings with interested parties.

4.4 Technical Assistance [Section 509 (a)(4)]

Technical assistance is requested in the following areas, listed according to priority:

1. Developing a standardized OFHS framework for program planning and accountability to include writing realistic and measurable objectives and the development of a monitoring and evaluation system for program activities and outcomes.
2. Developing a PRAMS or PRAMS-like surveillance system to monitor various components of risks impacting pregnancy outcomes.

V. SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children - A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adquecy of prenatal care. See *Adequate Prenatal Care.*

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see "Types of Services")

Measures - (see "Performance Measures")

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors
tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for

Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services

Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National “Core” Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets

Appendices

E. References
F. Organizational Charts
G. Resumes of OFHS Director and Division Directors
H. Memorandums of Agreement (MOA)